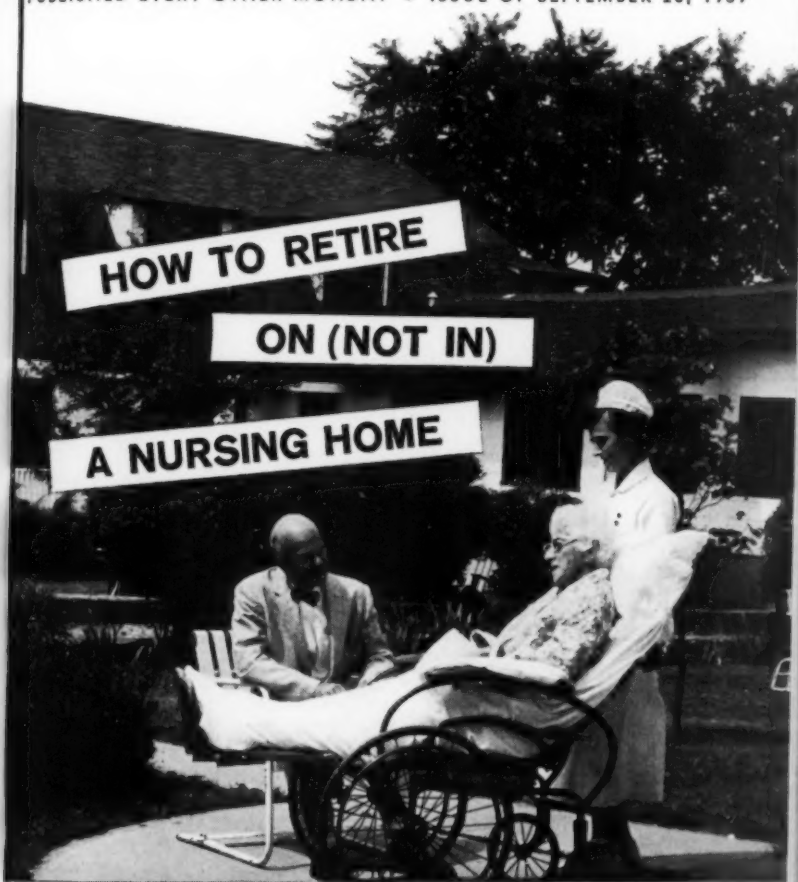


Medical Economics

PUBLISHED EVERY OTHER MONDAY • ISSUE OF SEPTEMBER 28, 1959



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1. Nulsen, R. O.: Ohio State Med. J. 53:665, 1957. 2. Personal communications: 1956-57. 3. Towne, J. E.: Internat. Rec. of Med. 171:584, 1958.

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Medical Economics

NEWS BRIEFS

THERE'LL BE STILL MORE SOCIALIZED MEDICINE in Britain if the Labor party wins next week's elections. The Laborites, who set up the National Health Service 11 years ago, say they'll boost its annual budget by \$280,000,000 if they win.

WHAT'S THE VALUE of the typical doctor's bag plus its contents? \$150, a new survey by this magazine shows. Yet only 46% of M.D.s insure their bags.

"GO TAKE A BROMIDE," a physician in San Francisco told a patient whom he didn't trust with sleeping pills. The patient did—5 bottles of it—then sued the doctor for giving him bromide poisoning. Now 2 courts have told the patient: You should have known "the proper dosage was [the one] on the label."

DON'T EXPECT PRICE BARGAINS in the new compact cars coming out now. Ford's new Falcon, for instance, if you want such "extras" as radio, heater, and automatic drive, will cost about \$2,350.

NEWS BRIEFS

ENTIRE PREMIUM of a health and accident insurance policy is a deductible medical expense, a Federal Court has recently ruled. The I.R.S. had maintained that only that portion of the premium which was allocable to health coverage was deductible.

THERE'S "WIDESPREAD AND INTENSE RESENTMENT against neglect, rudeness, and impersonal treatment by hospital personnel," Pollster Elmo Roper found in a recent survey for the United Hospital Fund. The result: Most people show a "lack of enthusiasm about supporting [hospitals] financially."

WHEN A CHIROPRACTOR RECENTLY CERTIFIED that 2 New York City teachers' absences were due to illness, N.Y. doctors instigated suit to keep Superintendent J.J. Theobald from giving them sick pay. Reason: Chiropractors aren't licensed in N.Y., can't certify anyone's illness. The suit was withdrawn when Theobald said he was paying the teachers only because their past work warranted it.

"LET'S FACE IT: Most hospital bills read like Chinese treaties—and people mistrust them," says American Hospital Association President Dr. R. A. Nelson. He believes all hospitals should use some sort of "bank examiner" accounting system "to show people they aren't being charged twice for something they get once."

YOU MAY SAVE by not having collision insurance if you leave it up to Uncle Sam. Net cost of repairs (after tax deduction) is often less than premiums.

LLOYD'S OF LONDON HAS HAD A SHARP DIP in profits the past 3 years despite a big rise in premium income. And London's Financial Times recently explained this phenomenon as follows: "People in America have taken increasingly to suing their doctors, their nursing homes, and even their lawyers for malpractice. In addition, American lawyers...have grown increasingly skillful at gaining the last legal cent for personal injury."

WANT TO KNOW THE AVERAGE PAY in your area for secretarial help? You can find out by writing the National Office Management Assn. in Willow Grove, Pa., for its latest clerical salary survey.

NEW KIND OF CLOSED-PANEL PLAN is being considered by a N.Y. hotel-workers' union. It has rejected Blue plans and 2 big closed-panel plans. Instead, it hopes to set up for its 46,000 dependents and members a comprehensive home, office, and hospital care plan "organized around 25 to 30 doctors' offices...equipped by the [union] and staffed by doctors and nurses employed by the [union] on a full-time salary basis, with the doctors' practices limited to treatment of members' families."

NEWS BRIEFS

M.D.s WHO ARE UNPAID CIVIC OFFICIALS now get a tax break from the I.R.S. Henceforth, any non-reimbursed expenses they incur while performing their official duties will "constitute charitable contributions and are deductible as such."

COVERAGE OF OUT-PATIENT DRUG COSTS will soon be offered by New York's United Medical Service (Blue Shield). It hopes to offer the coverage to groups that have its \$100-deductible service contract. Only the cost of doctor-prescribed drugs will be covered, not non-Rx or hospital drugs.

MEDICAL STUDENTS ARE BEING "SWINDLED" by training not geared to real life, Dr. J. H. Brotherston of Scotland warned U.S. doctors recently. He says they aren't taught that in real life "patients may be far from tame; they may talk back; they may even bite." In practice, he warns, such students may develop "a kind of veiled hatred for the patient because he does not behave as he should."

DEATH-KNELL HAS SOUNDED for "minimum-deposit" life insurance—the kind that lets you borrow against the policy's cash value to pay premiums. It's been banned in New York State effective Nov. 1, and insurance men predict other states may soon follow suit. The ban does not affect doctors who already have minimum-deposit policies.

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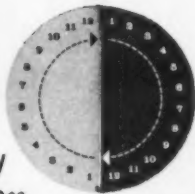
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Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, SEPT. 28, 1959

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A layman with a physician in his family blames the profession's 'superiority complex.' See any signs of it?

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That's the size of a recent jury verdict against two doctors and their hospital in a fatal transfusion case. This analysis of the apparent reasons for the verdict may help you guard against similar malpractice actions

How to Retire On (Not in) a Nursing Home96

This still-busy physician plans to combine a part-time retirement practice with a profitable investment in a growing field where his knowledge is badly needed. Here's an appealing idea that may be feasible for you, too

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Their usual fees amount to hundreds of dollars a year. Can you afford it? Or, since they've put some doctors thousands of dollars ahead, can you afford *not* to hire such help?

More►

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and fear of attacks

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
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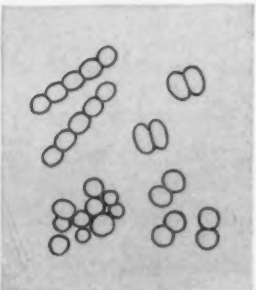
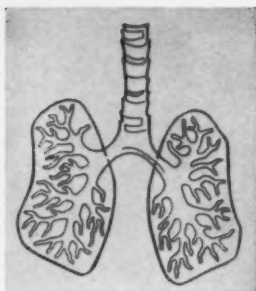
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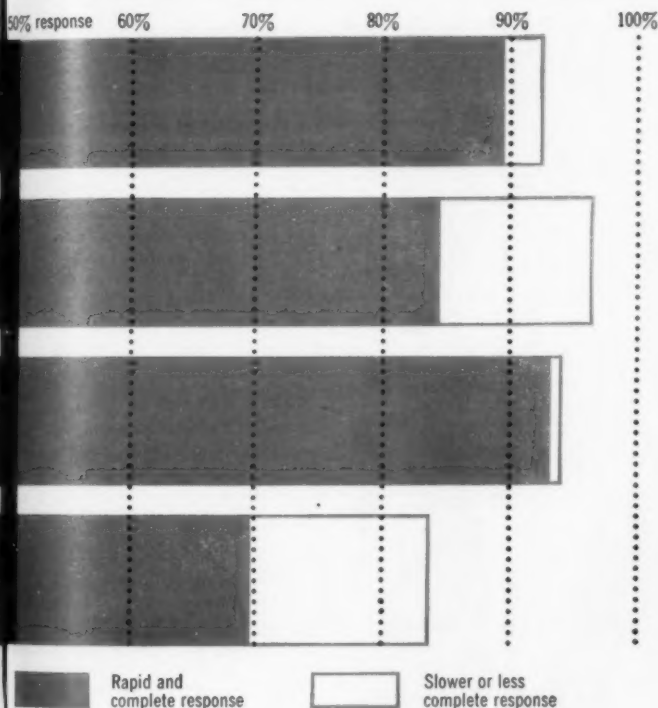
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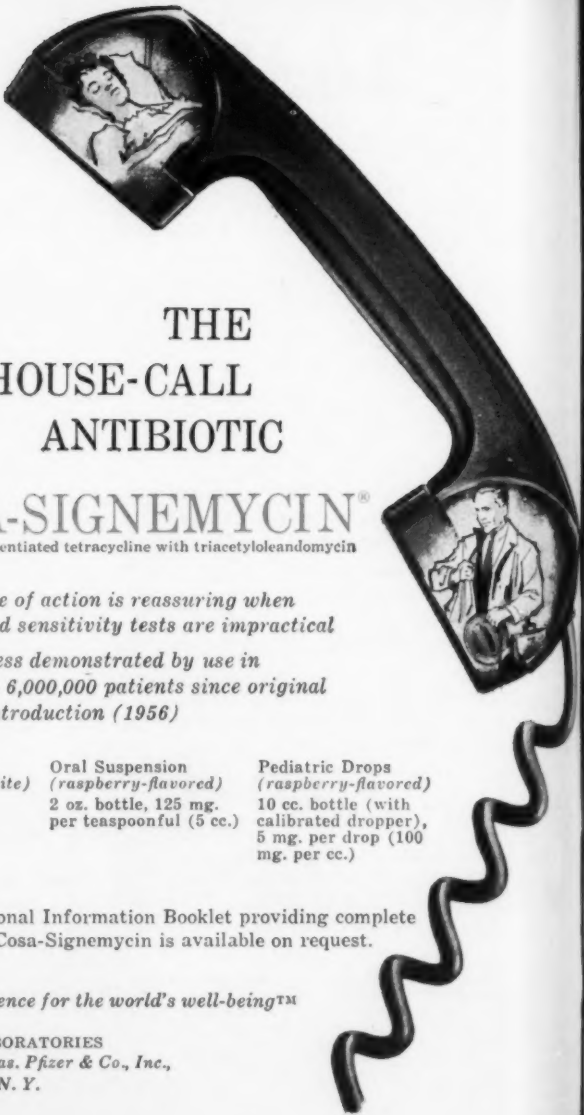
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
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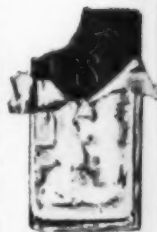
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Each nugget contains: Vitamin A—5,000 Units* / Vitamin D—1,000 Units* / Vitamin C—75 mg. / Vitamin E—2 Units† / Vitamin B₁—2.5 mg. / Vitamin B₂—2.5 mg. / Vitamin B₆—1 mg. / Vitamin B₁₂ Activity—3 mcg. / Panthenol—5 mg. / Nicotinamide—20 mg. / Folic Acid—0.1 mg. / Biotin—30 mcg. / Rutin—12 mg. / Calcium Carbonate—125 mg. / Boron—0.1 mg. / Cobalt—0.1 mg. / Fluorine—0.1 mg. / Iodine—0.2 mg. / Magnesium—3.0 mg. / Manganese—1.0 mg. / Molybdenum—1.0 mg. / Potassium—2.5 mg.

*U.S.P. UNITS †INT. UNITS

dosage: one Delectavites daily. **supply:** Box of 30 (one month's supply), Box of 90 (three months' supply).



WHITE LABORATORIES, INC., KENILWORTH, NEW JERSEY

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Letters

Patients Should Talk

SIRS: Office Designer Marshall Erdman says that most doctors shouldn't have consultation rooms, because patients will want to sit there and talk to him about their troubles.

But if a patient has troubles, his doctor should certainly know it. Otherwise, how can the physician see the whole picture? I'd hate to be under the care of the kind of "efficient" physician Mr. Erdman envisions. I'm sure Mr. Erdman would too.

Philip S. Barba, M.D.
Philadelphia, Pa.

Radiology Not for Amateurs

SIRS: Management Consultant Millard K. Mills recently told MEDICAL ECONOMICS readers how a suburban G.P. has saved time by having his secretary taught to take X-rays. Her X-rays are reportedly so good that a radiologist has praised them.

No doubt they are technically good. But as a radiologist myself, I'd like to point out that the average nonradiologist's secretary who takes X-rays seldom bothers to protect herself or the patients. This

means needless radiation of the gonads and, when the persons involved are under 45, needless hazards to unborn generations.

This is much more serious than we thought a decade ago. X-ray "photography" is no activity for amateurs unaware of the vital necessity for adequate gonad shields.

L. Henry Garland, M.B.
San Francisco, Calif.

Pay by the Hour?

SIRS: One of your recent correspondents has repeated a suggestion I've seen before in MEDICAL ECONOMICS: that doctors charge for their services on the basis of time spent. I regard this as extremely dangerous. In a subtle way, it reduces us from a profession to a trade. Most laborers charge on an hourly basis. Professional men charge what a given service is worth.

John H. DeTar, M.D.
Reno, Nev.

When Ability Doesn't Count

SIRS: "Good Practice Openings That Are Going Begging" presented a rosy picture of the practice



WHEN COUGH MUST BE STOPPED

Combines the antitussive potency of codeine with the safety of a placebo.¹ Raises the cough-reflex threshold promptly (15-30 minutes) for as long as six hours without side effects, without narcotic complications.¹⁻⁶

Three useful dosage forms: **Syrup**, butterscotch flavored, 15 mg per 5 cc—bottles of 4 oz, 16 oz and 1 gal. **Tablets**, sugar coated, 15 mg—packages of 20, 100 and 500. **Expectorant**, fruit flavored, 15 mg of Romilar and 90 mg of ammonium chloride per 5 cc—bottles of 16 oz and 1 gal.

References: (1) L. J. Cass, W. S. Frederik and J. B. Andosca, *Am. J. M. Sc.* 227:291, 1954. (2) N. Ralph, *Am. J. M. Sc.* 227:297, 1954. (3) L. J. Cass and W. S. Frederik, *New England J. Med.* 249:132, 1953. (4) H. Isbell and H. F. Fraser, *J. Pharmacol. & Exper. Therap.* 107:524, 1953. (5) *New and Nonofficial Drugs* 1959, Philadelphia, J. B. Lippincott Company, 1959, p. 326. (6) H. A. Bickerman, E. German, B. M. Cohen and S. E. Itkin, *Am. J. M. Sc.* 234:191, 1957.

Romilar® Hydrobromide—brand of dextromethorphan hydrobromide

Romilar

the specific non-narcotic antitussive with prompt, prolonged action!

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1.25 mg

REDUCE

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*In each 5

Romilar®

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WHEN COUGH IS A PART OF THE COLD COMPLEX

- CONTROLS COUGH** . . . with Romilar, 15 mg*
- COMBATS ALLERGIC MANIFESTATIONS** . . . with chlorpheniramine maleate, 1.25 mg*
- REDUCES NASAL AND BRONCHIAL CONGESTION** . . . with phenylephrine hydrochloride, 5 mg*
- RELIEVES HEADACHE AND MYALGIA, REDUCES FEVER** . . . with N-acetyl-p-aminophenol, 120 mg*

Two convenient dosage forms: **Syrup**, bottles of 16 oz and 1 gal. **Capsules**, bottles of 100.
 *In each 5 cc of syrup and in each capsule.

Romilar® Hydrobromide—brand of dextromethorphan hydrobromide

Romilar CF

a complete treatment for cough and other cold symptoms

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Letters

possibilities in small towns. But when one is 51 years old, like me, and would like to relocate, he's out of luck if he happens to be a naturalized citizen trained in a foreign school, or if he's been born into a creed that isn't considered acceptable in any particular neck of the woods. The fact that one state board has testified to his adequate training counts for nothing, reciprocity procedures being what they are.

Let's face facts: Young men

rarely want to settle in small communities. But many able and willing older physicians are disqualified for reasons that have nothing whatever to do with their professional, physical, and emotional competence.

Werner Sandelowsky, M.D.
Farmingdale, N.Y.

Medical Certificate Fees

SIRS: After twenty years of practice, I still find it awkward to handle requests for medical certificates in legal cases. Patients seem to feel entitled to them as a courtesy service; lawyers try to ignore the question of payment, and then



"ankle-itis"
yes, any rheumatic "itis" calls for
Sigmagen
salicylic acid-salicylate compound TABLETS

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TEDRAL[®] anti-H—dual seasonal protection for your pollen-sensitive asthma patients. Tedral anti-H—dependable Tedral antiasthmatic plus antihistaminic chlorpheniramine—assures simultaneous prevention of itching, sneezing and lacrimation of pollinosis *and* of the bronchospasm and mucous congestion of asthma. Adult Dose: 1 or 2 tablets q.4.h. plus an additional tablet at the *first* sign of an attack.

Formula: theophylline, 130 mg., (2 gr.); ephedrine, 24 mg., (3/8 gr.); phenobarbital, 8 mg., (1/8 gr.); chlorpheniramine, 2 mg., (1/32 gr.).

dual protection for pollen-sensitive asthmatics



Letters

reluctantly agree to a fee of \$10. Yet it takes me half an hour to an hour to write a competent certificate.

I see no reason why I shouldn't be expected to charge for this service. Does anybody?

Paul J. Halberstadt, M.D.
New York, N.Y.

Getting Rid of Patients

SIRS: Dr. John Stuyvesant's article "How I Weed Out Patients I Don't Want" is shockingly cyni-

cal. Our profession, we've boasted, serves everyone who needs us. Yet here's a man who coldly selects those who'll get his services. And with remarkable selfishness, he unloads the unacceptable ones on other doctors, actually giving his colleagues' names and addresses to the undesirables. This is buck-passing in spades.

Dr. Stuyvesant is certainly a shining example for those who accuse us of arrogance and of having lost the common touch.

M.D., Oregon

SIRS: ... The author advocates telling deliberate lies (he calls them



to relieve nausea and vomiting of pregnancy and accompanying g.i. discomfort

Investigators report that in the vast majority of patients 'Combid' *Spansule* capsules:

1. control nausea and vomiting of pregnancy all day and all night with just one dose q12h
2. reduce spasm and hypersecretion; relieve accompanying heartburn, distention and cramping
3. allay anxiety and tension often seen with nausea and vomiting of pregnancy

Each 'Combid' *Spansule* capsule contains Darbid® (brand of isopropamide), 5 mg., and Compazine® (brand of prochlorperazine), 10 mg.

Combid® **Spansule®**
b.i.d. brand of sustained release capsules



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for Certainty
against the Cocci

Erythrocin[®]

(Erythromycin, Abbott)

an uncommon antibiotic for common infections

Provides fast, high blood and tissue concentrations—plus an unparalleled safety record. Erythrocin is available in easy-to-swallow Filmtabs[®] (100 and 250 mg.); in tasty, citrus-flavored Oral Suspension (200 mg. per 5-cc. teaspoonful); and for intravenous and intramuscular use.



FILMTABS—FILM-SEALED TABLETS, ABBOTT, U.S. PAT. NO. 2,881,085

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MEDICAL ECONOMICS • SEPTEMBER 28, 1959 31

Letters

excuses) to his patients in order to get rid of them. Only as a last resort does he tell them honestly what he meant to say in the first place.

As members of the highest profession, we should not encourage dishonesty in the name of expediency. Our character must be stronger than that. Instead, let's urge our colleagues to face situations and deal with them honorably, instead of sneaking out from under them.

William Wolf, M.D.
New York, N.Y.

SIRS: If I used Dr. Stuyvesant's methods for brushing off the neurotic and the broke, I couldn't shave.

Archie R. O'Connor, M.D.
Clinton, Mich.

Write Lively, Please

SIRS: Regarding your recent articles and letters critical of science writers:

We do indeed strive to be entertaining. We're proud of whatever ability we have to make complex subjects both clear and interesting to the public.

And just as the best professor is usually an entertaining professor,

doctors would do well to live up to their own writings. (But I really hope they won't; if they did, they could put us science writers out of jobs.)

David M. Cleary, President
National Association of Science Writers
Upper Darby, Pa.

O.K. to Advertise?

SIRS: A few weeks ago, the A.M.A. delegates resolved that "medical care plans should be encouraged to increase their efforts to provide health education and information concerning the coverage of their subscribers."

Sounds good. Question: Will this make it possible for panel plans to indirectly self-advertise and so evade the ethical injunction against doing so?

This has already happened at least once: Brochures containing self-laudatory material were one cause of the hassle New York City physicians have had with H.I.P.

Are the bars now down? Should individual doctors do a little health promoting by mail?

M.D., New York

Law With No Teeth

SIRS: Your recent News item on "How Some Investors Beat the Margin Rules" notes that one loophole used by speculators is to buy stocks on margin, put them up as collateral for a bank loan, and then

IN G.I. DISORDERS...

keeps the mind
off the stomach
...the stomach
free of pain

Milpath

Miltown + anticholinergic

*re'lieves anxiety and tension
for enhanced antispasmodic effect*

now two Milpath forms
for adjustability of dosage

Yellow, scored tablets of 400 mg. mepro-
bamate and 25 mg. tridihexethyl chloride
(formerly supplied as the iodide). Bottle
of 50.

Dosage:

1 tablet t.i.d. at mealtimes and 2 at bed-
time.

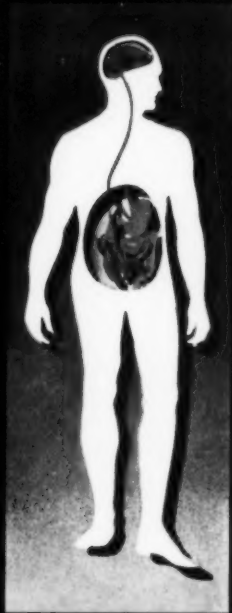
Yellow, coated tablets of 200 mg. mepro-
bamate and 25 mg. tridihexethyl chloride.
Bottle of 50.

Dosage:

1 or 2 tablets t.i.d. at mealtimes and 2 at
bedtime.

WALLACE LABORATORIES

New Brunswick, N. J.



Letters

go deeper into the market. You didn't point out that such transactions are against Federal Reserve Board regulations if the collateral consists of listed issues.

However, there's apparently no enforceable penalty for breaking the rule. So speculators will continue to use the loophole until some teeth are put in the law.

Lloyd Haas
New York, N. Y.

Too Frank About Fees?

SIRS: In his recent article "I'm Frank About Fees—So I Collect 98.5%," Radiologist Samuel I. Adelman says he either collects from the patient or presents a bill to him before the patient has left the office. Such a collection method seems extremely commercial. It's the sort of thing that makes the public feel that doctors are mainly interested in money.

I wonder how Dr. Adelman would feel if he were handed a bill as he left his dentist's office . . .

Walter Mayer, M.D.
Richmond, Va.

SIRS: . . . As a radiologist, Dr. Adelman is in an entirely different situation from that of a G.P., an internist, or a surgeon. The latter

depend on treating patients more than once. Besides, when people go to a radiologist, they expect to pay. This doesn't always hold true when they go to a doctor for medical care.

Jacob M. Bodenheimer, M.D.
Shreveport, La.

Business Crooks

SIRS: I got a kick out of your News report that an American Bar Association official suggests that the way to bring a gyp appliance dealer to book is to send him a complaint via registered mail, with a copy going to the Better Business Bureau.

It would be a tin-horn swindler indeed who'd be awed by a registered letter or upset by the unfavorable opinion of the Better Business Bureau. The crooks who gyped me out of nearly \$1,000 on the pretext of building some wall cabinets don't give two hoots in hell for the Better Business Bureau. They won't accept registered mail, ignore the county District Attorney, and laugh heartily at the Attorney General of the state.

If anyone's interested in a mine of information on how crooked operators *really* operate, let him communicate with me.

Lyon Steine, M.D.
Valley Stream, N.Y.
END

the orally effective
antifungal antibiotic for ringworm

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fulvicin*

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Schering

rapid clearing of ringworm of skin, hair and nails due
to Microsporum, Trichophyton, Epidermophyton organisms

*TM.

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the
inside
story†

†penetration—first *oral* fungistatic agent to permeate keratin *from inside out*—FULVICIN acts systemically on fungi in dermis, hair and nails

effectiveness—improves and clears tinea of scalp, body and feet in 2 to 3 weeks, of nails (onychomycosis) in 3 to 4 months, regardless of previous duration¹⁻³

...rapid relief of itching
...rapid loss of hyperkeratosis
...rapid return of normal perspiration
...rapid disappearance of viable fungi from infected hair and nails

safety—well tolerated in therapeutic doses...the few side effects reported (gastric discomfort, diarrhea and headache) are mild and transient

For complete information about dosage, indications and precautions consult the Schering Statement of Directions

Packaging: FULVICIN Tablets, 250 mg., bottles of 30.

References: (1) Williams, D. I.; Marten, R. H., and Sarkany, I.: *Lancet* 2:1212, 1958.
(2) Blank, H., and Roth, E. J., Jr.: *A.M.A. Arch. Dermat.* 79:259, 1959. (3) Goldfarb, N., and Rosenthal, S. A.: *Current M. Digest* 26:67, 1959.

of
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NEW
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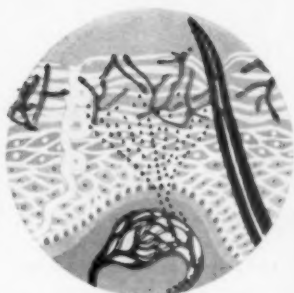
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now "a fundamentally new therapeutic approach"¹

in
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infections
of skin,
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and
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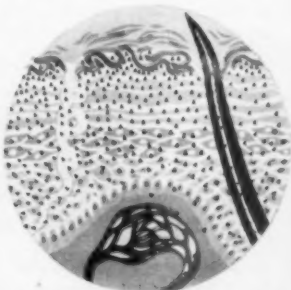
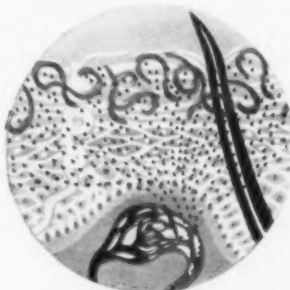
**FIRST
EFFECTIVE
PENETRATION
OF
KERATIN
—FROM
THE
INSIDE**



Pathogenic fungi invade and proliferate in the stratum corneum (and also in keratinized part of nails and hair), where they are usually inaccessible to treatment from the outside by topical antifungal agents, even with the aid of keratolytics.

Following oral administration, FULVICIN is absorbed and incorporated in newly growing dermal cells. As these cells approach the surface and become keratinized, they retain sufficient amounts of FULVICIN to provide fungistasis. FULVICIN has also been identified in hair shafts in fungistatic concentrations.²

**"CURLING
FACTOR"
INHIBITS
FUNGAL
GROWTH
—PERMITS
OUTGROWTH
OF
HEALTHY
TISSUE**



Hyphal (filamental) tips of fungi are curled, constricted and stunted by FULVICIN.³ Growth ceases, further penetration of keratin halts, and the fungal disease is arrested.

Fungus immobilized by FULVICIN is cast off as keratin grows out and sloughs off. Healthy tissue replaces infected keratin of skin, hair or nails.

References: (1) Williams, D. I.; Marten, R. H., and Sarkany, I.: *Lancet* 2:1212, 1958. (2) Gentles, J. C.; Barnes, M. J., and Fantes, K. H.: *Nature* 183:256, 1959. (3) Brian, P. W.; Curtis, P. J., and Hemming, H. G.: *Tr. Brit. Mycol. Soc.* 29:173, 1946.



FOUND:
a dependable
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gynecologic
office problem"

"VULVOVAGINITIS, CAUSED BY TRICHOMONAS VAGINALIS, CANDIDA ALBICANS, Haemophilus vaginalis, or other bacteria, is still the commonest gynecologic office problem . . . cases of chronic or mixed infection are often extremely difficult to cure." Among 75 patients with vulvovaginitis caused by one or more of these pathogens, TRICOFURON IMPROVED cleared symptoms in 70; virtually all were severe, chronic infections which had persisted despite previous therapy with other agents. "Permanent cure by both laboratory and clinical criteria was achieved in 56. . ."

Ensey, J. E.: Am. J. Obst. 77:155, 1959

TRICOFURON[®] Improved

■ Swiftly relieves itching, burning, malodor and leukorrhea ■ Destroys Trichomonas vaginalis, Candida (Monilia) albicans, Haemophilus vaginalis ■ Achieves clinical and cultural cures where others fail ■ Nonirritating, esthetically pleasing

2 STEPS TO LASTING RELIEF

1. POWDER for weekly insufflation in your office. MICOFUR[®], brand of nifuroxime, 0.5% and FUROXONE[®], brand of furazolidone, 0.1% in a water-dispersible base.
2. SUPPOSITORIES for continued home use each morning and night the first week and each night thereafter—especially during the important menstrual days. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

*Rx new box of 24 suppositories with applicator
for more practical and economical therapy*

NITROFURANS—a *unique* class of antimicrobials

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to relieve pain of dysmenorrhea...



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Zactirin[®]

Ethoheptazine Citrate with Acetylsalicylic Acid, Wyeth

ZACTIRIN will return many patients suffering from the pain of dysmenorrhea to normal physical activity. Its analgesic effect is equivalent to that of codeine, yet it is non-narcotic, hence has no addiction liability. Side-reactions are mild and low in incidence.

Supplied: Tablets, bottles of 48. Each tablet contains 75 mg. of ethoheptazine citrate and 325 mg. (5 grains) of acetylsalicylic acid.



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Uncoated Buffered Ferrous Sulfate

HIGHER ABSORPTION—LOWER DOSAGE

When FERMALOX is prescribed in anemia "satisfactory clinical response is obtained with 44% of U.S.P. dosage."¹ Uncoated FERMALOX tablets disintegrate rapidly making more iron available for immediate absorption in the duodenum producing increased utilization.

Gastric irritation is virtually eliminated with FERMALOX due to the buffering action of MAALOX. Many patients who can't take iron *can* take FERMALOX.

Each FERMALOX tablet contains: Ferrous sulfate 200 mg.; MAALOX-Rorer (Magnesium-aluminum hydroxides) 200 mg.
Dosage: 2 tablets daily; often may be reduced to 1 tablet daily after 15 days.


Offered: Bottles of 100 tablets at prescription pharmacies.



1. Price, A.H. et al.: J.A.M.A. 167:1612, 1958.

WILLIAM H. RORER, INC.

Philadelphia 44, Pa.



preferred
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**because Neo-Polycin Ointment
helps clear
topical infections
promptly**

Neo-Polycin® provides neomycin, bacitracin and polymyxin, the three antibiotics preferred for topical use because this combination is effective against the *entire* range of bacteria causing most topical infections...has a low index of sensitivity...and averts the risk of sensitization to lifesaving antibiotics, since these agents are rarely used systemically. And Neo-Polycin provides these three antibiotics in the unique Fuzene® base, which releases higher antibiotic concentrations than is possible with grease-base ointments.

Each gram of Neo-Polycin contains 3 mg. of neomycin, 400 units of bacitracin and 8000 units of polymyxin B sulfate in the unique Fuzene base. Supplied in 15 Gm. tubes
PITMAN-MOORE COMPANY, DIVISION OF ALLIED LABORATORIES, INC., INDIANAPOLIS 6, INDIANA



delivers more steroid to the site of inflammation

NASAL SPRAY NEO-HYDELTRASOL®

Prednisolone 21-phosphate with Propadrine², Phenylephrine[®] and Neomycin

Only NEO-HYDELTRASOL provides its steroid component in true solution—a definite therapeutic benefit, since in pure solution more of the steroid is immediately available to inflamed nasal mucosa.

The anti-inflammatory action of the prednisolone 21-phosphate is reinforced by two valuable decongestants—for fast and prolonged action—and neomycin to combat intranasal infection.

Supplied in 15-cc. plastic spray bottles
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FILIBON adds one essential ingredient to the accepted prenatal supplement... assurance of nutritional support each day throughout pregnancy because the decorative jar on her table will remind your patient to take FILIBON daily. The extended FILIBON formula compensates for fetal drain on maternal vitamin-mineral reserves; includes vitamin K and AUTRINIC® Intrinsic Factor Concentrate, always enhancing B₁₂ uptake. Excellently tolerated iron (ferrous fumarate) and the oil-free, small capsules help prevent aggravation of "morning sickness" or intestinal distress... and insure daily acceptance. Dosage: 1 capsule daily. For complete formula see Physician's Desk Reference page 688.



Phosphorus-free
FILIBON®
Prenatal
Capsules
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LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

anorectal comfort in minutes



Anusol-HC

dependable Anusol Hemorrhoidal Suppositories with hydrocortisone (10 mg.)

Anusol

Hemorrhoidal Suppositories and Unguent

in hemorrhoids proctitis pruritus ani

START with *Anusol-HC* . . . eliminate inflammatory symptoms rapidly and safely with 2 Suppositories daily for 3 to 6 days. **MAINTAIN** with *Anusol* . . . prevent recurrence of symptoms and promote more rapid healing with 1 Suppository morning and evening and after each bowel movement. Supplement with *Anusol* Unguent as required. Neither *Anusol-HC* nor *Anusol* contains any narcotic or analgesic drug, thus will not mask symptoms of serious rectal pathology.



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News

Doctors Find Landlord Role a Profitable One

Many doctors look to the stock market to make their savings grow. But others have found that putting their money to work right in their own profession can build their capital faster. Here's a case in point, as disclosed recently by a well-known management consultant:

A few years ago, a group of his clients—seven physicians and a dentist—put up \$5,000 apiece to build an office building for themselves.

Other doctors liked their set-up. So the original investors went into the real-estate business on the side and added sixteen suites of offices.

By investing just \$500 more apiece, and by increasing their mortgage loans, they financed two additions providing space for another dozen doctors.

How profitable an investment has this been? The value of each partner's original share has multiplied more than five times in less than five years. This came to light recently when one of the partners died. His estate received \$27,500

for his original \$5,500 investment.

What made their building project a success? "They planned it right," says the management consultant, by:

¶ Building near a hospital and in an area where real estate values were going up.

¶ Providing a parking area that's large enough for all future needs.

¶ Signing up all tenants in advance and seeing that they included a variety of specialists, but not too many of any one type.

\$1-Extra Scheme Backfires, Brings in More Patients

One doctor whose patients were queuing up during his evening office hours recently hit on a scheme to make some of them come in during the afternoon. It didn't work out as planned, but somehow he's not complaining.

Dr. O. S. Jones of St. Louis keeps his office open three nights a week to accommodate working people. Not long ago, he noticed that "old ladies of 75" were trooping in during these hours because "it was cooler" then. In addition, many children were coming at

—News—

night because "Daddy could bring us." As a result, the doctor found he was seeing an average of nineteen patients at night and only eight in the afternoon.

In an attempt to reverse this pattern, Dr. Jones raised his night office visit fees by a dollar. And he put up a sign to this effect in his waiting room.

The result? He now sees an average of sixteen patients in the afternoon—and seventeen at night.

"Well, anyhow, the government is doing better," he remarks. As

for himself, after taxes and those long evening hours, he's not so sure.

One Way to Avoid Taxes On Stock Profits

Many a doctor-investor with diversified holdings has found that his stocks have posted good gains during the past year, but his bonds have sagged. There's a way to turn this situation into tax savings, investment advisers are now telling their clients. Here's how:

Suppose a physician paid \$5,000 for some bonds several years ago. Now they're selling for \$4,400. Suppose, too, that early this year

Treat the *Entire Hemorrhoidal Syndrome*
with

PNS[®] *rectal suppositories*



ANESTHETIC - Pontocaine[®] HCl (10 mg.)

—prolongs surface analgesia
without irritation.

DECONGESTANT - Neo-Synephrine[®] HCl (5 mg.)

—reduces swelling and engorgement
promptly — for extended periods.

ANTI-INFECTIVE - Sulfamylon[®] HCl (200 mg.)

—is effective against both gram-
positive and negative bacteria.

— Supplied in boxes of 12 —

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SYMPTOMATIC RELIEF ... AND FAST

from the

DRIP AND STUFFINESS

associated with

COMMON COLD

'FEDRAZIL'[®]

Sugar-coated Tablets

**... contain an orally effective nasal decongestant
combined with a good antihistamine**

Dose: 2 tablets initially, then one every 3 or 4 hours as needed

Each sugar-coated tablet contains:

'Sudafed'[®] brand Pseudoephedrine Hydrochloride . . . 30 mg.

'Perazil'[®] brand Chlorcyclizine Hydrochloride 25 mg.



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MEDICAL ECONOMICS • SEPTEMBER 28, 1959 47

*Superior
control
of Leukorrhea*
LYCINATE
**SEEKS OUT,
EXPOSES and
DESTROYS the**
exudate-protected Trichomonad and Monilia



Lycinate accomplishes the two factors essential to successful therapy in Leukorrhea:

- first*—Penetrates the mucopurulent barrier surrounding the hidden pathogens.
second—Effectively kills these offending pathogens.

Lycinate, through extremely effective mucolytic action, penetrates, exposes and then destroys these organisms by both chemotherapeutic and lysing actions.

Sustained effectiveness is insured by 'round-the-clock tablet disintegration.

Each buffered Lycinate tablet contains as active ingredients:
Dilodihydroxyquin 100 mg.
Sodium lauryl sulfate 5 mg.
Diactyl sodium sulfosuccinate 5 mg.
Dextrose, anhydrous 650 mg.

dosage: 1 or 2 vaginal tablets inserted simultaneously once daily.

supplied: Boxes of 50 with applicator.

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—News—

he bought some stock on which he now has a paper profit of \$600. He doubts it'll go higher.

How can he take his stock profit, avoid taxes on it, and still maintain a defensive position in bonds? Well, if he follows the experts' advice:

1. He sells the bonds and scores a \$600 capital loss for income tax purposes.

2. He puts the proceeds from the sale into other bonds selling at about the same price.

3. He sells his stock and takes his \$600 capital gain. He doesn't have to pay taxes on this stock profit, thanks to the offsetting loss he took on the bonds.

Federal Judge Advocates 'Narcotics Year'

"Just to go through the gesture of sending people to Lexington, Ky., or some other institution . . . is not going to get us anywhere . . . [Such] institutions really serve as nothing more than a revolving door!"

That's a Federal Judge's slant on the narcotics problem in New York. Judge William B. Herlands burst out with this opinion after sending the fifth defendant in one day to the narcotics treatment center at Lexington. "[I'm] shocked by the large number of these narcotics cases," he said. And by the

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combination test for *protein*
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for glycosuria

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A FULL RANGE OF DIETARY AND THERAPEUTIC SUPPORT FOR **OLDER PATIENTS**

B-COMPLEX VITAMINS

Thiamine Mononitrate, 5 mg.; Riboflavin, 5 mg.; Pyridoxine Hydrochloride, 1 mg.; Nicotinamide, 20 mg.; Calcium Pantothenate, 5 mg.

OIL SOLUBLE VITAMINS Vitamin A, 1.5 mg.(5000 units); Vitamin D, 12.5 mcg.(500 units); Vitamin E, 10 Int. units

HEMATOPOIETIC FACTORS

Vitamin B₁₂, with Intrinsic Factor Concentrate, $\frac{1}{2}$ U.S.P. Unit (oral); Ferrous Sulfate, U.S.P. (Elemental Iron—15 mg) 75 mg.; Folic Acid, 0.25 mg.

CAPILLARY STABILITY Ascorbic Acid, 50 mg.; Quertine® (Quercetin, Abbott), 12.5 mg.

LIPOTROPIC FACTORS Betaine Hydrochloride, 50 mg.; Inositol, 50 mg

ANTI-DEPRESSANT Desoxyn® (Methamphetamine Hydrochloride, Abbott), 1 mg

HORMONES Sulestrax® (Piperazine Estrone Sulfate, Abbott), 0.3 mg.; Methyltestosterone, 2.5 mg.



News

number of repeat cases, he implied.

What's the answer? More medical research, Judge Herlands believes: "Perhaps if we had an International Narcotics Year"—like the recent International Geophysical Year—"all research [could be] concentrated [and] something could be achieved."

'Emergency Service Is for Patients, Not Doctors'

Emergency call services are meant to help the public get a doctor in a hurry. They're not meant to help doctors take time off. This distinction was drawn recently by the Erie County (N.Y.) medical society. Here's what led up to it:

A small number of doctors were leaving town for a day or a week-end without arranging for a colleague to care for their patients. Instead, they were telling their patients to call the emergency service if they needed help.

Dr. Thomas S. Bumbalo, the society's president, spoke up sharply about this habit: "That was not the

purpose for which this public service-public relations program was established." Other medical leaders warned that offending doctors could be prosecuted for unprofessional conduct under the State Education Law. (It says a doctor must make specific arrangements for the care of his patients while he's away.)

After these warnings, the society got tough. It threatened to turn offenders in to the ethics committee, then maybe to the state medical society.

All this has apparently checked misuse of the emergency call service. Says Dr. George L. Collins Jr., chairman of the Committee to Supervise Emergency Medical Service: "I haven't heard a single complaint since we got tough."

Physicians Protest Extra Charge for 'MD' Plate

Medical men in one state are objecting loudly because their "MD" license plates have just been ruled a luxury. As a result, they'll have to pay \$10 extra for them.

New Jersey's 8,000 physicians were notified recently that the state has put a new levy on all "courtesy" plates with special identifying letters. Doctors' plates are included.

But they shouldn't be, the state medical society says. The "MD" plates aren't just a courtesy to phy-



Bumbalo

important new psychoactive agent

- revitalizes depressed patients—elevates mood, increases alertness and ability to maintain work and social adjustment
- relieves pain in angina pectoris
- lessens fatigue, aching, stiffness in rheumatoid arthritis

WITHDRAWN BITTER DESPAIRING
SOMBER HOPELESS CRUSHED

when the words mean
depression,
effective treatment is

Catron®

β -phenylisopropyl hydrazine supplied as the hydrochloride

CATRON® is the original brand of β -phenylisopropyl hydrazine. It is supplied as the hydrochloride in press-coated, unscored tablets of 3 mg. (blue), and 6 mg. (pink), bottles of 50.



For detailed information request Brochure No. 19, CATRON.

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News

sicians. They're a public service, so that anyone can identify a doctor's car in case of an emergency.

What's more, says the state society president, Dr. F. Clyde Bowers: "To convert them into prestige plates is to impose upon physicians an unwarranted discrimination."

But this same "discrimination" falls upon a lot of people, replies Ned J. Parsekian, head of the state motor vehicle division. And he has no authority to make exceptions. "Even the Governor will have to pay \$10 extra if he wants special plates," he adds. "Why shouldn't doctors?"

Clinic Wins Right to Be Taxed Like Corporation

The chances of a medical group's winning the right to be taxed like a corporation—and the right to give doctor-members tax-sheltered employee benefits—are getting better all the time. The latest break came when a U.S. District Court in Dallas ruled that the Southwest Clinic Association has all the attributes of a corporation and should be taxed like one.

This is the second case where courts have backed up an unincorporated group's claim to corporate tax treatment. The first such case

—the Kintner case—was decided several years ago in Montana. The Internal Revenue Service has since agreed to go along with the Kintner case. It has also promised to issue regulations on how doctors' groups could qualify. But as yet, it hasn't issued them.

To see where it stood under the law, the Southwest Clinic Association deliberately let part of its profit accumulate one year instead of paying it out to the members. Forced by the I.R.S. to pay taxes on his share, Senior Partner Sidney Galt sued for a refund.

He won his refund—\$161.46 plus interest. More important, the decision opens the way to thousands of dollars in potential tax savings for Dr. Galt and all the other members of the group. For example:

¶ Group life and health insurance premiums paid by the clinic can be tax-deducted by it; and they aren't considered taxable income to the doctors.

¶ If a group doctor becomes sick or disabled, up to \$100 a week of his pay is tax-free.

¶ If a group doctor dies, the clinic can pay up to \$5,000 to his widow, tax-free.

¶ If the clinic sets up a qualified pension or profit-sharing plan for its doctors, the clinic gets an immediate tax deduction for its contributions; but the doctors aren't

New reinforced therapy
from Schering
for seasonal asthma
and allergic dermatoses

What's its name?

Polanil

What's its rationale?

POLANIL combines two of nature's major antihistaminic effects of histamines and suppresses the inflammatory response and therefore, is ideally suited for use in allergic conditions where histamine release and the inflammatory response are not the only factors in the allergic reaction.

What's its concept?

POLANIL is a new concept in the treatment of allergic conditions. It combines the antihistaminic effect of dextro-chlorpheniramine maleate with the corticosteroid effect of dexamethasone.

POLARAMINE, the closest to a perfect antihistamine.
DERONIL, today's lowest dosage corticosteroid.
POLANIL

SCHERING CORPORATION • BLOOMFIELD, NEW JERSEY

What is it?

POLANIL is dextro-chlorpheniramine maleate (**Polaramine® Maleate**) — the closest to a perfect antihistamine and dexamethasone (**Deronil®**) — today's lowest dosage corticosteroid.

What are its advantages?

POLANIL combines the powerful antihistaminic effect of dextro-chlorpheniramine maleate with the corticosteroid effect of dexamethasone. POLANIL is the closest to a perfect antihistamine and dexamethasone. POLANIL is a new concept in the treatment of allergic conditions. It combines the antihistaminic effect of dextro-chlorpheniramine maleate with the corticosteroid effect of dexamethasone.

How is it supplied?

POLANIL is supplied in two strengths: 1 mg. and 2 mg. tablets. It is also available in a syrup form. For more information, contact your nearest Schering representative.

Schering

News

taxed until they retire and begin to draw payments.

¶ All doctor-members of the clinic come under Social Security.

How was the Southwest Clinic Association set up in order to gain such benefits? Like a corporation, (1) it held title to all the property of the group; (2) it was a continuing body that couldn't be affected by the death or resignation of any member; (3) it had a centralized management directed by an executive committee; (4) it had some limitation on the personal liability of the individual members; and (5) it had full control over the doctor-members and all other employees, including the right to hire and fire.

With those features, said Federal Judge T. Whitfield Davidson, the doctors ran the clinic "substantially the same as if they had been incorporated under the corporation laws of the state." Because of that, he concluded, they should be taxed "as though they were incorporated."

The Galt decision has already touched off a new wave of interest among doctors in corporate-like practice. Until the I.R.S. issues its long-awaited regulations, it may very well challenge other groups like the Southwest Clinic. But with

a second favorable court decision on the books—and in a second Federal Court jurisdiction—tax men say the road ahead should be considerably smoother.

What's 'Negligence' in One State Isn't in Another

Many medicolegal men insist that the "res ipsa loquitur" doctrine is used to determine liability for medical mishaps more often in some states than in others. Now there's new evidence to support this theory. It comes from two almost identical malpractice suits decided recently in New Jersey and California.

Both suits involved patients who were injured by injections. In the New Jersey case, a man suffered pain and numbness in his leg after an injection in which his sciatic nerve was damaged. In the California suit, a woman developed phlebitis after getting an injection in a varicose vein in her leg.

New Jersey's Superior Court has ruled that the doctor involved in the first case was not at fault: "We cannot say that the occurrence here ordinarily bespeaks negligence . . . The damaging effect of this injection might well have ensued consistently with the exercise of ordinary professional care."

But in the second case, the Supreme Court of California holds

even if
your

patient
is a
mud
chicken†

he won't be mired for long once he's on

PARAFON*

PARAFLEX® + TYLENOL®

for muscle relaxation *plus* analgesia

and in arthritis

PARAFON*

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†surveyor, to non-engineers

prescribe PARAFON in low back pain
—sprains—strains—rheumatic pains

Each PARAFON tablet contains:
PARAFLEX® Chlorzoxazone† . . . 125 mg.
Specific for skeletal muscle spasm
TYLENOL® Acetaminophen . . . 300 mg.
The analgesic preferred in
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Supplied: Tablets, scored, pink, bottles
of 50.

Dosage: Two tablets three or four times
a day.

Each PARAFON WITH PREDNISOLONE
tablet contains: PARAFLEX® Chlorzoxa-
zone† 125 mg., TYLENOL® Acetamino-
phen 300 mg., and prednisolone 1.0 mg.
Supplied: Tablets, scored, buff colored,
bottles of 36.

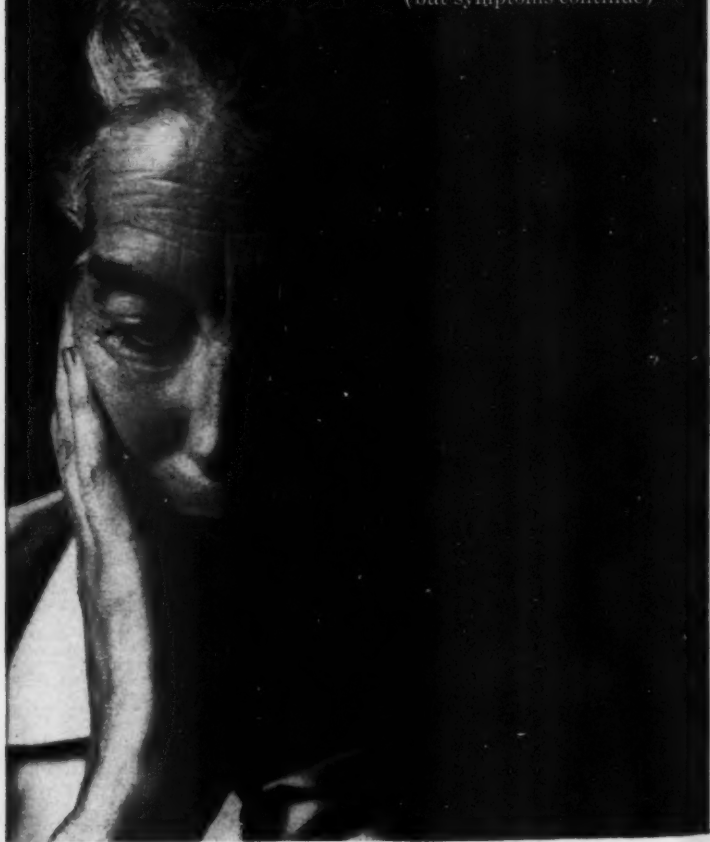
Dosage: One to two tablets three or four
times a day.

Precautions: The precautions and con-
traindications that apply to all steroids
should be kept in mind when prescrib-
ing PARAFON WITH PREDNISOLONE.

†Trade mark

U. S. Patent Pending

when her periods stop ...
(but symptoms continue)



p...start

TACE

(chlorotrianisene)



Symptom-free adjustment to the postmenopausal state

New estrogen approach to the postmenopause

Menopausal distress rarely ends with cessation of menses. Indeed, symptoms are often intensified following the sharp drop in available endogenous estrogen during the early postmenopause.

At that time — when periods stop but symptoms continue — TACE is most valuable.

Note this essential difference between TACE and other estrogens: TACE stores in body fat, releases slowly, evenly, in the same manner as a natural hormonal secretion. A normal course of TACE therapy is 30 or 60 days. But even after the therapy, estrogenic activity continues, gradually tapers off, finally is exhausted in about 2 months.

This unique "self-regulating" property results in several advantages. Since sudden endometrial change doesn't occur, withdrawal bleeding rarely occurs. Complicated dosage adjustment is unnecessary. Finally, there are no "peak-and-valley" estrogenic effects. The result is a smooth, symptom-free adjustment to the postmenopausal state.

You can observe this unique effect in your patients. Simply prescribe two TACE 12 mg. capsules daily for 30 days. A severe case may require an additional 30-day course.



THE WM. S. MERRELL COMPANY
New York • Cincinnati • St. Thomas, Ontario

TRADEMARK REGD.

News

that the injury is clear-cut negligence on the doctor's part: "It is a matter of common knowledge among laymen that injections . . . do not ordinarily cause trouble unless unskillfully done."

Society Promotes Inspection To Counter X-Ray Alarm

In many cities, newspaper headlines have proclaimed the radiation hazards of X-ray equipment—and thereby made patients apprehensive about all X-ray diagnosis and treatment. But in Evansville, Ind., the doctors have moved swiftly to forestall such apprehension. In the process, they've made some wholesome headlines of their own.

How did Evansville doctors do it? Acting through their Vanderburgh County Medical Society, they sponsored voluntary inspections of all local X-ray equipment. Then they took the results to local newspapers. Soon local people got the news:

¶ All X-ray equipment belonging to members of the medical society, plus the equipment in five hospitals, had been inspected by two certified radiation physicists.

¶ All the equipment inspected had been found in safe condition or had been made so immediately after the survey.

¶ Each physician was present when his equipment was checked, so that the radiation physicists could check his X-ray techniques.

Pleased by the public response, Evansville doctors are now considering repeating their survey periodically. One unpublicized reason: It may be good protection against malpractice suits based on the harmful effects of radiation.

Legal authorities expect many such suits in the years ahead. A physician whose equipment has passed inspection is going to be better able to defend himself, these sources say.

New Kind of Life Insurance Would Cope With Inflation

Every doctor with life insurance faces this problem: Will inflation shrink the value to his family of the cash benefits by the time they're paid out?

This question is raised by an independent insurance expert, Consulting Actuary Maurice H. LeVita of Washington, D.C. His prediction: To solve the problem, the insurance industry will soon come up with a new kind of life insurance. He calls it tentatively "variable dollar life insurance." It would be geared to the stock market, and its cash value would fluctuate with the market and the cost of living.

A precedent for this new kind of policy would be a device that's now

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QUESTION:

Why is Bellergal an unusually effective adjunct in functional gynecologic disorders?

ANSWERS:

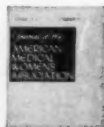
Quoted from published reports of leading clinicians.



"A more uniform and prolonged relief of tension [and other major complaints of functional gynecologic disorders] may now be obtained by use of Bellergal Spacetabs." (Stewart, R. H.:

West. J. Surg. 64:650, Dec. 1956.)

"...of 125 women who presented climacteric symptoms...73 responded [to a 2 to 4 week course of Bellergal therapy] so well that the dose was reduced...or the drug was completely discontinued. Some now only take a few tablets to help them through critical situations..." (Kavinoky, N. R.: *J. Am. M. Women's A.* 7:294, Aug. 1952.)

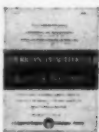


"...the combination of drugs present in Bellergal served admirably [in premenstrual tension and disturbances of the menopause] in the reduction of symptoms, both as to degree and number.

The improved sense of well-being offers satisfactory evidence that such patients may derive considerable benefit from this simple method of treatment." (Craig, P. E.: *M. Times* 81:485, July 1953.)

"...of 303 gynecologic patients [premenstrual tension, dysmenorrhea, menstrual irregularity, postmenstrual tension]... a total of 90 per cent of the cases were benefited by the use of this drug."

(MacFadyen, B. V.: *Am. Pract. & Digest. Treat.* 2:1028, Dec. 1951.)



for functional disorders
of
menstruation and menopause



BELLERGA[®]
Spacetabs[®]

effectively relieve distress of
hot flashes...sweating...
headache...fatigue...irritability...
palpitation...insomnia

BELLERGA[®] SPACETABS

Bellafoline 0.2 mg., ergotamine tartrate 0.6 mg., phenobarbital 40.0 mg.
Dosage: 1 in the morning, and 1 in the evening.

BELLERGA[®] TABLETS

Bellafoline 0.1 mg., ergotamine tartrate 0.3 mg., phenobarbital 20.0 mg.
Dosage: 3 to 4 daily. In more resistant cases, dosage begins with 6 tablets daily and is slowly reduced.



NOW—YOU CAN PRESCRIBE THE UNSURPASSED ADVANTAGES OF ARISTOC

superior antiallergic efficacy
with new low dosage

NEW

Aristoc

- combines the anti-inflammatory, antiallergic and antihistaminic effects of two agents—ARISTOCORT and chlorpheniramine which, separately, have been proved highly effective in the treatment of allergy
- permits greater latitude in adjusting dosage to minimum level needed for maintenance, because ARISTOCORT and chlorpheniramine are supplied in the lowest dose tablets available for each component alone
- supplies ascorbic acid for increased demand in stress conditions

Indications: Generalized pruritus of allergic origin; hay fever, allergic rhinitis, perennial asthma, seasonal and perennial rhinitis, vasomotor rhinitis; drug reactions and other allergic conditions.

Dosage: One to eight capsules a day in divided doses. Dosages should be established on the basis of individual therapeutic response.

Precautions: Drowsiness may occur, and is usually due to the antihistamine effect. Occasionally this may also cause vertigo, pruritus and urticaria. Because of the low dosage, side effects with ARISTOMIN have been relatively infrequent and minor in nature. However, since ARISTOCORT Triamcinolone is a highly potent glucocorticoid with profound metabolic effect, all precautions and contraindications traditional to cortico-

steroid therapy should be observed. Discontinuance of therapy must not be sudden after patients have been on steroids for prolonged periods. It must be carried out gradually over a period of as much as several weeks.

Further information available on request.

Supply: Each ARISTOMIN Capsule contains:

ARISTOCORT® Triamcinolone 1 mg.

Chlorpheniramine Maleate... 2 mg.

Ascorbic Acid..... 75 mg.

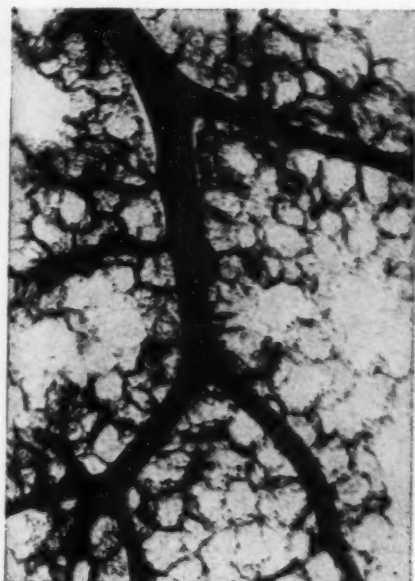
Bottles of 30 and 100

References: 1. Maurer, M. L.: Clinical Report, cited with permission. 2. Levin, L.: Clinical Report, cited with permission. 3. Gaillard, G. E.: Clinical Report, cited with permission.

ES OF **ARISTOCORT IN ANTIHISTAMINE COMBINATION**

to min[®]

Steroid-Antihistamine Compound **LEDERLE**



(lung x 65, injected with carbon-gelatin)

*comments by
clinical investigators:*

"I would conclude that ARISTOMIN is truly a worthwhile aid in treating allergic problems."¹

"The results have been uniformly good. The patients have stated that their symptoms were very much relieved. I have not encountered any side reactions except from one patient, who complained of some drowsiness, which I attribute to the antihistamine."²

"In general . . . it [ARISTOMIN] is an excellent product. Over-all, it appears to be more effective than any simple antihistamine we have used. Despite the fact that we employed it in the treatment of a variety of nonselected individuals and problems, we had excellent and good results in 25 of the 39 patients."³

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

News

protecting some doctors' retirement incomes: the variable annuity. The doctor who buys such an annuity in effect buys into a portfolio of common stocks. The value of his annuity rises and falls with the market value of that portfolio. The idea is to keep inflation from eating away at the doctor's retirement income.

Now LeVita maintains that it's just a matter of time before a life insurance policy will be on the market with its cash pay-off protected in the same way.

ID Cards for Everybody? Soon, Says This M.D.

Diabetics and others often carry medical identification cards for emergencies. But should everyone have to? Yes, says a doctor who's also a syndicated columnist. What's more, he predicts such cards will soon be required.

"The day is not far off when every man, woman, and child in the United States will be required to carry an I. I. (illness identification) card," Dr. Peter J. Steincrohn recently told



Steincrohn

his readers. "Health is not only your own personal problem; it is also our Government's."

What would the Government want noted on a patient's I. I. card? A brief medical history, including mention of any allergies, says Dr. Steincrohn. He points out that this would also help doctors whose patients forget to give them such information.

Change the Abortion Laws? '90% Break Them Now'

How far should a doctor go to get public support for his views on abortion laws? One doctor who wants the laws liberalized wrote a mass-circulation magazine article to say so. Newspapers thought his story so startling that they put it in headlines.

"After thirty-odd years of medical practice, I am convinced that the abortion laws in the United States make hypocrites of all of us," wrote Dr. Alan F. Guttmacher in Redbook. Using his own hospital (New York's Mt. Sinai) as an example, he noted:

"The law of New York [State] permits abortion only to preserve the life of the mother. In the six years 1953 to 1958, my own obstetrical service . . . performed 147 therapeutic abortions . . . By the strictest interpretation of the law . . . more than 90 per cent of these 147 abortions were illegal." *More ▶*

NEW AND EXCLUSIVE . . . the only 5-action,
one-tablet treatment...for comprehensive
control of your asthma patients, prescribe

TRADEMARK

BRONKOTABS

THESE DISTURBING PHENOMENA



APPROPRIATELY CONTROLLED

BY A ONE TABLET FORMULA:

1. Bronchospasm	→ Bronchodilator	← Ephedrine sulfate, 24 mg.
2. Local bronchial edema	→ Diuretic	← Theophylline, 100 mg.
3. Allergic complications	→ Antihistaminic	← Thenyldiamine HCl, 10 mg.
4. Tenacious mucus	→ Expectorant	← Glyceryl guaiacolate, 100 mg.
5. Anxiety-tension	→ Sedative	← Phenobarbital, 8 mg.

CLINICALLY PROVEN—good to excellent results in 91% of 593 patients.¹

WELL TOLERATED—side effects in these studies mild and temporary—incidence only 4.7%.¹

INDICATIONS—For prevention or relief of the symptoms of allergic asthma, asthmatic bronchitis, chronic bronchitis with emphysema, emphysematous bronchospasm. Also for the relief of bronchial asthma associated with hay fever, allergic rhinitis and nonseasonal upper respiratory allergies.

DOSAGE: Adults: one tablet every 3 or 4 hours, four to five times daily. Children over six: one half the adult dosage.

Available at all pharmacies.

FOR PROMPT
EMERGENCY RELIEF

BRONKEPHRINE® hydrochloride
(ethylnorepinephrine-Breon—10 cc. vials 2 mg./cc.)

"... far more than a substitute for epinephrine..."²



GEORGE A. BREON & CO., NEW YORK 18, NEW YORK

1. Personal communication. 2. Foland, J. P.: Postgrad. Med. 18:397 (Nov.) 1955.

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Then Dr. Guttmacher explained why these "illegal" operations had been performed:

¶ "For psychiatric reasons." Though most of these patients had threatened suicide, he said, "pregnant women threatening suicide rarely carry out their threats. [Anyway] these women could have been placed in protective custody."

¶ "For eugenic reasons, to forestall the birth of children likely to be born with severe abnormalities." Added Dr. Guttmacher: "No mother's life is threatened by such a birth."

¶ For reasons related to cancer—i.e., the mother had it or had just been operated for it. "No lives actually were preserved among these women either," Dr. Guttmacher commented.

¶ For reasons related to the threatened loss of some important function—i. e., the mother's sight or ability to walk.

All these reasons are valid grounds for abortion, Dr. Guttmacher believes. So he thinks the law should be loosened to accommodate them. He'd like to see new abortion laws "patterned after [those] in Norway, Sweden, and Denmark." Apart from strictly medical reasons, these countries permit therapeutic abortions:

1. "For general health . . . too many children, or children too close together."

2. "For eugenic reasons."

3. "For humanitarian reasons—a pregnancy resulting from rape or incest or the impregnation of a girl less than 15 years old."

Who would administer such laws in this country? Suggests Dr. Guttmacher: "Special boards [of] obstetricians, gynecologists, psychiatrists, internists, geneticists, and sociologists. Such an arrangement would take abortion out of the hands of the individual doctor and hospital."

Credit Card to Pay M.D.s? Society Warns Against It

Should doctors honor credit cards for payment of medical bills? This question is a matter of curiosity in many parts of the country. But it's a matter of immediate concern to California doctors, because banks there are trying to enroll them in credit-card plans. And the San Francisco Medical Society, for one, says it "could not recommend that physicians participate in such schemes."

How would such schemes work? According to a medical society investigating committee, they'd be much like charge systems used by department stores and oil companies.

"A small stamping machine,



Four weeks ago, Mrs. C. was an anxiety patient, complaining of weakness, trembling, sweating, tachycardia, on the slightest

exertion. Her symptoms followed family reverses; home life became disorganized, she couldn't cope with housework.

Therapy with TRILAFON, 4 mg. t.i.d., and a weekly office visit to discuss her feelings have worked wonders in reactivating this patient. She's on maintenance dosage now, 2 mg. t.i.d., able to work very well, and wide-awake and active all day long.

mobilizes patients immobilized by anxiety

Trilafon[®]
perphenazine

when you want to avoid drowsiness

- helps the patient contain anxiety, tension
- restores normal working capacity

TRILAFON Tablets—2 mg. and 4 mg.; bottles of 50 and 500.

TRILAFON REPETABS,® 8 mg.—4 mg. for prompt effect in the outer layer and 4 mg. for prolonged relief in the timed-action inner core; bottles of 30 and 100.

For complete details on TRILAFON consult Schering literature.

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News

similar to those used in gas stations, would be installed in the office of the participating physician," the committee explains. He'd use this to make out patients' bills. Then he'd send a copy of each bill to the bank. There they'd be credited as payments to the doctor's account.

Such a plan, if widely used, says the committee, would have these advantages:

¶ "It would lessen the total accounts receivable on the doctor's books at any one time."

¶ "Bad debt losses would be practically nil."

¶ With the bank acting as collector, it would free the physician from "the potential difficulties of collection."

But credit cards would also have these drawbacks, according to the medical society investigating committee:

¶ Doctors might find themselves involved in advertising schemes to sell the program.

¶ At least one of the credit-card plans would list all participants in a directory. Such listings have always been considered unethical advertising.

¶ Each doctor would have to pay \$25 for his billing machine, plus \$1 a month service charge.

And he'd pay a collection fee, too, maybe as high as 6 per cent.

Weighing these pros and cons, the San Francisco Medical Society came out with its negative recommendation. But so far that hasn't stopped the banks. One bank alone says it's aiming at a state-wide membership of more than 5,000,000 in its credit-card plan.

'Better Call Yourself a Small Businessman'

Doctors may be proud of their role as public servants. But it's a role they shouldn't talk about too much. They'll preserve private medicine a lot longer if the public learns to think of them as small businessmen. That's the belief of Dr. T. K. Callister of Pacific Palisades, Calif.

He notes that people now think of medicine as a "social field, inextricably tied . . . to concepts of public welfare." This makes doctors an easy mark for "the fast-flowing tide of welfare and security socialization," he reasons.

But suppose doctors cut loose from "this social concept of medicine as a humanitarian art." Suppose they identified themselves with the field of small business and private enterprise. Then, declares Dr. Callister, they'd be a lot better off. He explains:

"It is simply a matter of shifting emphasis in public relations." Call-

now potent tranquilizer therapy is safer than ever

MELLARIL is virtually free
of such toxic effects as

- jaundice
- Parkinsonism
- blood dyscrasia



Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—discarded from such "diffuse" effects as anti-emetic action.

Thioridazine [MELLARIL] is as effective as the best available phenothiazine, but with appreciably less toxic effects than those demonstrated with other phenothiazines. . . . This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."



Mellaril®

Thioridazine HCl
specific, effective tranquilizer • safer at all dosage levels

remarkable lack of side effects

In more than 3,000 carefully-followed patients, Mellaril has been almost completely free of such major side effects as jaundice, extrapyramidal symptoms, Parkinsonism, blood dyscrasia, dermatitis—even when given in quantities far in excess of the usual dosage.

POVERTY OF SIDE EFFECTS "The most striking aspect of thioridazine [Mellaril] therapy is the poverty of side effects. . . . In its lack of side effects and low toxicity, it is superior to all other tranquilizing drugs tested."²

NEGLECTIBLE SIDE EFFECTS "Side effects were negligible at all dosage levels: no incidence of parkinsonism or other extrapyramidal symptoms. Minimal sedation, on the whole lower than with other tranquilizing agents. No alteration in liver function, urine or blood. No photosensitivity. Patient acceptability was exceptional: lack of drowsiness, lethargy or 'washed out' feeling, permitted patients to carry on normal everyday activities. Orthostatic hypotension was absent. The initial 'keyed up' tense feeling common to other drugs of this type was absent."³

SINGULARLY FREE OF SIDE EFFECTS "It is singularly free from the side effects ordinarily seen with these [phenothiazine] compounds."⁴

ABSENCE OF SIGNIFICANT SIDE EFFECTS "None of the following toxic effects, so common after administration of the phenothiazines, was present during the period of Thioridazine administration: Parkinsonism or Parkinson-like symptoms, photosensitivity, orthostatic hypotension, bone-marrow depression."¹

MINIMAL SIDE EFFECTS "Side effects such as extrapyramidal activity, jaundice and photosensitivity have not been observed in patients treated with Thioridazine [Mellaril]. Extrapyramidal side effects produced by other phenothiazines have disappeared promptly with no deterioration in the behavioral response when these patients have been shifted to Thioridazine."⁵

NO JAUNDICE "No allergic reactions were observed such as skin eruptions, jaundice or agranulocytosis. Central nervous system toxicity, as manifested by extrapyramidal effects, seizures, and excitement did not occur despite the use of high doses (up to 2000 mg.) of the drug."⁶

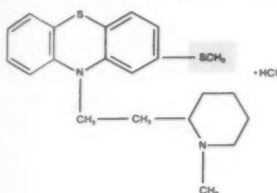
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specific, effective tranquilizer • safer at all dosage levels



greater specificity of tranquilizing action

plus fewer side effects



The presence of a thiomethyl radical (S-CH₃) is unique in Mellaril and could be responsible for the relative absence of side effects and greater specificity of psychotherapeutic action. This is shown clinically by:

- 1 A specificity of action on certain brain sites in contrast to the more generalized or "diffuse" action of other phenothiazines. This is evidenced by a lack of appreciable anti-emetic effect.

MELLARIL

PSYCHIC RELAXATION
DAMPENING OF SYMPATHETIC AND PARASYMPATHETIC NERVOUS SYSTEM

Minimal suppression of vomiting
Little effect on blood pressure and temperature regulation

Psychic relaxation
Dampening of sympathetic and parasympathetic nervous system

Minimal suppression of vomiting
Little effect on blood pressure and temperature regulation

other phenothiazine-type tranquilizers



- 2 Less "spill-over" action to other brain areas—hence, absence of undue sedation, drowsiness or autonomic nervous system disturbances.
- 3 A notable absence of extrapyramidal stimulation.
- 4 Lack of impairment of patient's normal drive and energy.
- 5 Virtual freedom from toxic effects—jaundice, photosensitivity, skin eruptions, blood forming disorders have been absent in reports currently available.

These properties add up to a greater margin of safety.

Mellaril®

specific, effective tranquilizer • safer at all dosage levels



excellent clinical response

In office practice and in hospitalized patients, Mellaril has proved highly useful for a wide variety of major and minor emotional disorders (such as anxiety, tension, apprehension, alcoholism, agitated psychoneurosis, agitated psychotic states, etc.).

EXTREMELY SATISFACTORY "... produced extremely satisfactory results in the broad therapeutic range represented in this series."³

POTENT AGENT "... appears to be a potent agent in the symptomatic management of a variety of psychiatric states."⁴

MAJOR ADDITION TO THERAPEUTICS "This drug appears to represent a major addition to the safe and effective treatment of a wide range of psychological disturbances seen daily in the clinics or by the general practitioner."¹

AN ACTIVE AGENT "Thioridazine is an active therapeutic agent. ... It is effective in a variety of psychiatric disorders, including schizophrenic reactions. ... The drug is particularly advantageous for a group of schizophrenic patients who are sometimes made worse by other phenothiazine derivatives or Rauwolfia alkaloids. It should also be suitable for treating patients with psychoneuroses and chronic brain syndrome."⁶

EVEN IN VERY SEVERE CASES "Of the 152 patients treated 25 have been released and they have not suffered a relapse. This proportion is significant if we stop to consider that we are dealing only with acute cases which had been considered hopeless and obviously destined to finish their days in an asylum."⁷

EXCELLENT THERAPEUTIC RESPONSE "Patients with emotional tensions resulting from the stress and strain of life ... were treated with Mellaril at the dosage level of 10 mg. three times daily. In 94 such patients, 83 obtained an excellent therapeutic response."⁸

Mellaril®

used for effective tranquilization at all dosage levels



"...extremely satisfactory results..."
in a clinical spectrum ranging from
minor nervous disorders to
severe psychotic disturbances³

RESULTS WITH MELLARIL IN 194 PATIENTS³

ACUTE PSYCHOTICS

83% satisfactory effect

Some cases had complete remission of symptoms. Most were able to return home to useful occupations.

CHRONIC PSYCHOTICS

68% satisfactory effect

Relief of symptoms in cases permitted easier management and a return to a more or less useful life.

NEUROTICS

57% satisfactory effect

Some cases, complete relief of symptoms. Other cases, partial relief of symptoms.

RESULTS WITH MELLARIL IN PATIENTS PREVIOUSLY TREATED WITH OTHER TRANQUILIZERS³

DIAGNOSTIC CATEGORY	IMPROVED %	VERY SATISFACTORY %	SATISFACTORY %	UNSATISFACTORY %
SCHIZOPHRENIA				
Acute	80	61	28	11
Chronic paranoid	84.2	31.6	52.6	15.8
Chronic, other	73.9	21.7	52.2	26.1
Residual	57.1	9.5	47.6	42.9
CHRONIC BRAIN SYNDROME	66.6	33.3	33.3	33.3
CHRONIC PSYCHONEUROSIS	62.5	12.5	50	37.5
CHRONIC PSYCHOSOMATIC DISORDERS	75	25	50	25

Mellaril®

low side effect • effective tranquilizer • safer at all dosage levels



a guide to administration and dosage

Dosage ranges from 10 mg. three or four times a day in milder situations to 25 mg. three or four times a day for more disturbed patients. In ambulatory psychiatric outpatients, dosages of 50 to 100 mg. three or four times a day have been found adequate. For severely disturbed hospitalized psychotics, dosages of 200 to 300 mg. three times a day may be administered. Dosage must be individualized according to the condition and degree of response. In all cases, the smallest effective dosage should be determined for each patient.

INDICATION	USUAL STARTING DOSAGE	TOTAL DAILY DOSAGE RANGE
ADULTS		
Mental and Emotional Disturbances:		
MILD —where anxiety, apprehension and tension are present	10 mg. t.i.d.	20-60 mg.
MODERATE —where agitation exists in psychoneurosis, alcoholism, intractable pain, senility, etc.	25 mg. t.i.d.	50-200 mg.
SEVERE —In agitated psychotic states as schizophrenia, manic depressive, toxic psychoses, etc.:		
Ambulatory	100 mg. t.i.d.	200-400 mg.
Hospitalized	100 mg. t.i.d.	200-800 mg.
CHILDREN		
BEHAVIOR PROBLEMS IN CHILDREN	10 mg. t.i.d.	20-40 mg.

PRECAUTIONS: Although possessing a unique structure and a selectivity of action which broadens its therapeutic ratio, the physician should be alert to the possibility of untoward reactions in certain susceptible individuals. In particular, he should watch for potential hemopoietic depression, jaundice or orthostatic hypotension. As with other phenothiazines, Mellaril is contraindicated in severely depressed or comatose states from any cause.

SUPPLIED: MELLARIL Tablets, 10 mg., 25 mg., 100 mg. Bottles of 100.

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News

ing yourself a small businessman "is a safer and more sophisticated approach. [It has already] done much to assure the integrity of private enterprise in insurance, banking, and public utilities."

Furthermore, says Dr. Callister, medical public relations should try for the same effect. "Let [it] define the doctor as an individual businessman confronted with all the human problems of making a living." Let it show him "worrying, like all businessmen, about his own lack of security." And let doctors speak to the public, "not as the A.M.A., but through its very grass-roots, the county medical societies."

'Most Attractive M.D.' Attracts Funds

Who is Montana's most attractive physician? That question seemed to have fund-raising possibilities to medical leaders in that state. So they rigged up a novel contest for the state medical association's annual meeting this month. The rules:

1. No women could enter. But women's auxiliaries got to nominate the candidates.
2. Candidates had to be 65 or over and still engaged in active practice.
3. Candidates didn't "have to be anybody's husband."

Any society member could vote

as often as he wanted—but each vote cost 5 cents. The association planned to donate the proceeds to the American Medical Education Foundation.

M.D.s Defeat Two Laws to Put Doctors on Payrolls

In many areas this year, doctors have been on the alert to block changes in state laws governing the practice of medicine. And in at least two states, they seem to have won important victories for private practice.

In Wisconsin, hospitals failed to get legislation that would have enabled them to "engage" certain specialists and bill patients for their services without mentioning the specialists' names. And in Texas, closed-panel advocates failed to get the law changed to allow the hiring of doctors by nonprofit corporations.

Here's what happened in Wisconsin:

The state hospital association introduced a bill that would have allowed hospital corporations (1) to hire anesthesiologists, pathologists, physiatrists, and radiologists; and (2) to bill for their services at a profit to the hospital—which the medical society charged was "fee splitting."

More▶

News

The hospitals, said the medical society, had introduced the bill without consulting doctors. What's more, the medical society feared the bill would have opened the way for hospitals to hire *any* doctor on salary.

So representatives of the medical society met with hospital representatives to talk the problem out. It took most of the spring and summer. But finally both groups came up with a bill they agreed upon. As enacted by the Legislature, it appeared to be just what Wisconsin doctors wanted.

The bill's main points can be summarized as follows:

1. Hospitals may contract for the services of certain specialists but may not hire them on salary or create any employer-employee relationship.

2. Hospitals may bill patients for the services of such specialists—but only if they list the doctor by name along with the services he performs.

Meanwhile, here's what was happening in Texas:

The bill introduced there would have further restricted the grounds for refusing licenses to practice medicine. According to the Texas Medical Association's legal counsel, Philip R. Overton, this would

have made it legal for any panel plan to "employ physicians, sell their services, and collect the fees."

Medical society opposition helped keep the bill in committee. And it was still there when the Legislature adjourned.

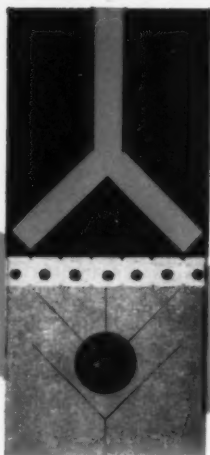
Internists Set Up a Model Relative Value Scale

Internists have long complained that most fee schedules don't define the procedures of internal medicine and don't assess their true value. Two years ago, they formed the American Society of Internal Medicine to help correct this situation. Now this society has developed a model relative value scale.

Using the routine office visit as its basic unit of one point, the internists' scale assigns higher point values to the more time-consuming procedures they perform. A complete diagnostic examination is rated at five points. It's worth five times as much as a routine office visit, the internists say, because it usually takes at least an hour. Point values are also assigned to such special cases as prolonged stays with patients who are critically ill.

Internists aim to make these point values part of any new value scale drawn up by state societies of internal medicine. They've already succeeded in doing so in about twenty states.

END



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**Dulcolax — in either
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form — insures
gentle but effective
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**Works exclusively
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**Acts on the large
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**Is equally effective
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Something to remember about mouthwashes...



There may come times in the course of your daily practice when you are asked to recommend a mouthwash—for a scratchy throat, for example, or a "furry" taste, or bad breath, or general oral hygiene.

If this question is asked, Doctor, you may suggest Listerine Antiseptic without any cautions whatsoever.

The Listerine formula, as you may know, is all but identical to that of *liquor antisepticus*, as listed in the National Formulary.

Listerine is not only effective, it is completely safe, even for small children. And Listerine Antiseptic is on hand and available in more U. S. homes than all other mouthwashes combined.

If you would like Listerine Antiseptic for home or office use, the special offer below might well be worth your consideration.

SPECIAL PROFESSIONAL OFFER—PROFESSIONAL GALLON SIZE \$2.50

Fill out the coupon below and send it in with your professional card and check or money order for \$2.50 made out to Lambert Pharmacal Company Division and receive prepaid a full gallon of Listerine Antiseptic.

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Lambert Pharmacal Company Div., Morris Plains, N. J.

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Why Claysorb means more effective antidiarrheal treatment

The response to an antidiarrheal preparation is directly linked to the effectiveness of its adsorbent. In both POLYMAGMA and POLYMAGMA Plain, the new agent Claysorb* gives you a previously unattainable adsorptive power... proved to be five times beyond that of kaolin in removing diarrhea-causing toxins. In addition, POLYMAGMA and POLYMAGMA Plain protect the irritated intestinal walls, promote well-formed stools, help restore healthy intestinal function.

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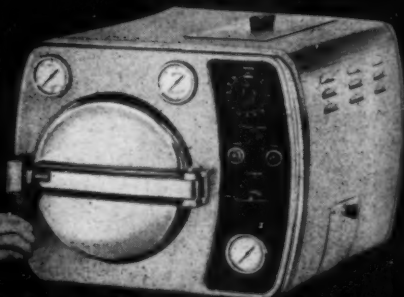


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All the splendid features of the popular, double-jacketed FL-2 and HP-2 autoclaves PLUS:

- + SINGLE KNOB CONTROL.
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To sterilize, simply turn control knob to STER, set timer for length of cycle. When exhaust light indicates conclusion of the cycle, turn control knob to EXHAUST, unload the chamber. Complete operation is simplicity in the highest degree.

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VITAMINS:

Vitamin B ₁₂ crystalline	5 mcg.
Vitamin B ₂ (riboflavin)	10 mg.
Vitamin B ₆ (pyridoxine hydrochloride)	2 mg.
Vitamin B ₁ mononitrate	10 mg.
Nicotinamide (niacinamide)	100 mg.
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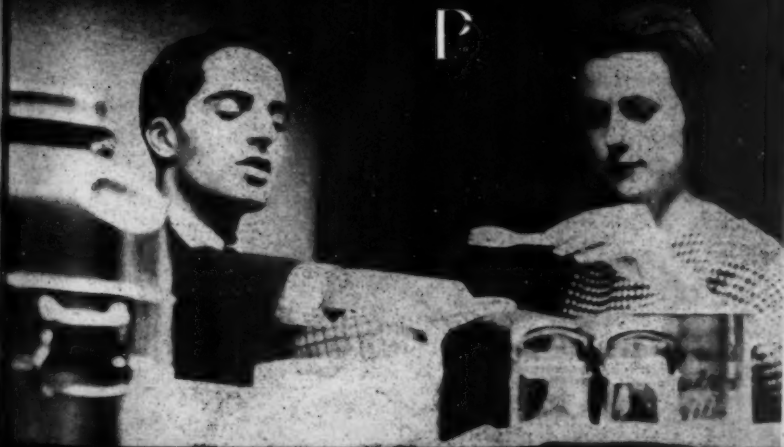
Iodine	0.15 mg.
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Bottles of 30, 100, 250, and 1,000.

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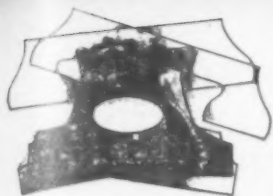
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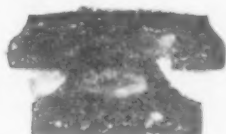


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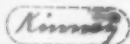
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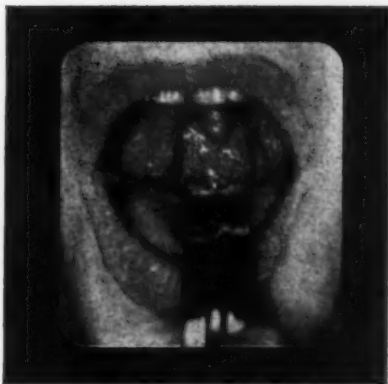
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REFERENCES: 1. Clinical reports to CIBA.

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Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS, SEPT. 26, 1959

Why Some People No Longer Love Doctors

A layman with a physician in his family blames the profession's 'superiority complex.' See any signs of it around you?

By L. K. Williams, PH.D.

Disregarding the risks, my wife's sister recently married a physician. As a result, I've been accepted into the medical family, though very much as an in-law. I've even been permitted to leaf through one doctor's top-secret files of MEDICAL ECO-

NOMICS. I'm grateful for the experience. My brother-in-law is not an ophthalmologist, but he has opened my eyes to a world I used to see only dimly.

Medical men, I now know, are fighters. The chip on the shoulder has apparently superseded

THE AUTHOR, a professor of history at a college in Pennsylvania, writes here under a pen name. His views aren't those of this magazine. But they're held by enough people to be worth correcting (if untrue) or otherwise acting on (if true). This article is copyrighted © 1959 by Medical Economics, Inc. It may not be reproduced, quoted, or paraphrased in whole or in part in any manner whatsoever without the written permission of the copyright owner.

WHY SOME PEOPLE NO LONGER LOVE DOCTORS

the caduceus as their symbol. The pages of the magazine to which I timidly submit this article pulsate with anger:

Dare the public resent the high incomes you amass by ministering to their fragile bodies? Let the public know that you damn well *earn* your fortunes! Let the public know that you worked hard and made harsh sacrifices in order to achieve your current high eminence. Let

the public know that if anybody doesn't like you—as you are, you'll drop him from your patient-list. Is the bread you offer stale and dry, baked in the economic ovens of yesteryear? Let 'em eat Socialistic cake—and happy bellyache to 'em!

Doctor, Doctor! May I be permitted a word, as a man who wishes you well now that you've married into his family? Do stop confusing your prerogatives with



"She says she doesn't need any X-rays. Her chiropractor has already taken some."

those of hereditary royalty. Do try to love us laymen a bit more, instead of trying to bludgeon us into loving you. I don't want your head to roll, any more than you want it to.

This Doctor Earns \$8,000

I'm a doctor too: a Ph.D. I spent four hard years in college and four more in graduate school, preparing for my profession as a healer (of man's spirit, if not of his body). I wrote a long and expensive dissertation in order to win my degree and get my first job as a history instructor in a small college. Now I'm a mighty professor. But I must continue to write for the scholarly journals—without remuneration—if I want to maintain my position. I net \$8,000 a year before taxes. And God knows how I shall send my son to college.

I don't complain about this, mind you. But I do complain about your assumption of economic superiority. Presumably, you chose your calling, as I chose mine, with some foreknowledge of its pains as well as its pleasures. Presumably, too, you realize that change is the law of life. But the outsider who

listens to your angry lamentations would never guess it.

You want and expect *medical* progress. Yet you resist every *social* step in any direction but backward.

Is it surprising that many thoughtful Americans, who continue to consult you when necessary and to pay your bills when required, have substituted a grudging respect for their former love of your profession? Is it any wonder that some of us have even begun to question your clinical judgment—in view of your fragmentary understanding of the nonclinical facts of life?

Socialization Ahead?

The pompous may inherit the world, but they generally lose it. I fear that unless America's doctors shed their excess fatuousness, my sister—who deserves a kinder fate—will eventually find herself married to a government servant.

Why? Well, let me tell you what it's like to visit a doctor's office these days. A few months ago, I had to consult a young internist. I didn't like the experience, but I took it lightly, because I assumed the doctor was atypical. [More on 200]



THE \$150,000 BLOOD TRANSFUSION

That's the size of a recent jury verdict against two doctors and their hospital in a fatal transfusion case. This analysis of the apparent reasons for the verdict may help you guard against similar malpractice actions

By John R. Lindsey

In the next twelve months, some 2,500 Americans are likely to die because something went wrong in a blood transfusion. And many of the 5,000-odd doctors involved may well face lawsuits as a result.

Is there a way to head off any such suit? Or to win it if it goes to court? Yes. The doctor is probably in the clear if he can prove that the transfusion was medically indicated and that

there was no contributory negligence on his part.

But it's growing increasingly difficult *not* to be negligent in the eyes of the law. "Every bottle of blood is a bottle of dynamite," says Dr. Lester J. Unger, director of the blood bank of New York University-Bellevue Medical Center.

Adds Dr. Jacob Geiger, chief of the blood bank at New York's Lenox Hill Hospital: "So many

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things can go wrong in the laboratory or at the bedside! Rh-positive blood can go to an Rh-negative patient. There can be a mix-up in names. Most baffling of all, there's no foolproof test to detect such diseases as hepatitis or malaria in the blood.

"Certainly," he says, "the blood transfusion technique has improved tremendously in recent years. Perhaps for that very reason, doctors tend to forget the tremendous medical and legal hazards of blood transfusions."

The legal hazards have been pointed up dramatically in a recent malpractice trial that resulted in a jury verdict of \$150,000 against two doctors and their hospital. The verdict is one of the largest on record in a blood transfusion case. And it's apparently the highest ever in a malpractice case involving the death of a nonworking housewife.*

*One reason the verdict was so big was that the trial judge admitted expert testimony on the cost of bringing up children who have lost their mother. For a discussion of this aspect of the case, see "Why You Can Expect More \$150,000 Malpractice Verdicts," MEDICAL ECONOMICS, Aug. 3, 1959.

What happened? Why was the case lost by the three defendants? Here's the full story:

On Jan. 30, 1958, a 25-year-old woman was admitted to St. John's Riverside Hospital in Yonkers, N.Y., for treatment of a kidney condition. There was a match-head-sized calculus trying to pass through the lower portion of the right ureter. The calculus was interfering with the passage of urine and jeopardizing the right kidney. The kidney, already damaged from congenital kinking at the upper end of the ureter, wasn't functioning and was in danger of complete destruction.

On Feb. 5, the woman's attending physician, Dr. Stanford Pulrang of Yonkers, successfully performed a pyeloplasty, removing the kinks from the ureter, and a nephrostomy that provided adequate drainage for the kidney while the stone was passing. Before the operation, he had ordered a pint of blood to be available for transfusion should it prove necessary. But it was never used. Said Dr. Pulrang later: "This blood remained in

THE \$150,000 BLOOD TRANSFUSION

the blood bank available for my patient only, at any time I needed to use it."

Later attempts to remove the ureteral stone by cystoscopy failed. So on Feb. 21, Dr. Pulrang performed a second operation. And it was during its course that a fatal mistake was made:

The Unread Label

When a circulating nurse employed by the hospital found a note on her desk saying, "The patient's blood is in the refrigerator," she wrongly assumed that the blood was for the woman in the operating room. So she gave the bottle to the anesthetist on duty, who was a lay employe of Anesthesiologist Harold Rubin. (Dr. Rubin wasn't present during the operation.) Neither the nurse nor the anesthetist noticed that a slip of paper accompanying the bottle identified the blood as intended for an entirely different patient, who'd been operated on earlier that day.

Even more surprisingly, while the nurse was in the operating room, the phone rang just outside the door. The call, which she took, was from the hospital laboratory. It was trying to locate a missing bottle of blood. She

didn't tell the lay anesthetist about the call at the time. But later, when the lab phoned again, she asked the anesthetist to take the call. By that time, however, the transfusion was already under way.

In the meantime, the anesthetist had turned to Dr. Pulrang, who was operating, and had said: "Doctor, I have a pint of blood for this lady. Shall I give it to her now?"

According to testimony at the trial, the surgeon replied: "Yes, give it to her."

Thus, the patient was given a transfusion of B-positive-type blood, although her own blood type was O-positive. Ten hours later, she was dead.

Three Defendants

Not long afterward, her husband—and the father of her two infant children—brought suit. He brought it against Dr. Pulrang; against the hospital, as the employer of the circulating nurse who'd made the initial error; and against Dr. Rubin, as the employer of the anesthetist who'd failed to discover the error. And a jury found all three defendants liable.

Why was Dr. Pulrang, the sur-

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WHOSE MISTAKE led to the \$150,000 award? Hospital Counsel Dennis L. O'Connor (left) blamed two doctors. Emile Zola Berman (right), lawyer for the plaintiff, blamed the hospital as well—and so did the jury.

geon in charge of the operation, held liable? Was it simply because he was "the captain of the ship" in the operating room, and because something went wrong under his command?

The answer is important as a guide in determining doctors' legal responsibility in blood transfusion situations. If the attending physician could be held liable for the negligence of all persons working under his supervision, surgeons might face an entirely new legal risk in blood transfusion cases.

But Dr. Pulrang wasn't held liable solely as "the captain of the ship." The trial judge, Justice Robert Doscher of the Supreme

Court of New York, explained later: If Surgeon Pulrang had merely ordered a transfusion as medically indicated, and if there'd then been a mix-up in names, the court would have directed the jury not to find the surgeon liable.

In other words, as Justice Doscher sees it, the surgeon in charge isn't liable unless there's negligence on his own part. In this particular case, Dr. Pulrang was found negligent because he hadn't specifically ordered a blood transfusion at the time of the operation.

The jury apparently felt that the doctor should therefore have questioned whether the patient's

THE \$150,000 BLOOD TRANSFUSION

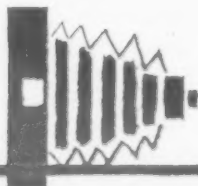
blood could have been ready.

To quote one of the trial lawyers: "If Dr. Pulrang had said, 'What blood? I didn't order any blood,' we wouldn't be here in court."

In his own defense, the surgeon pointed out that he *had* ordered—though he hadn't used—500 cc.s of blood for the patient in the Feb. 5 operation. Thus, he argued, he knew that the hospital had the blood prepared in

case it were needed on Feb. 21. He was busy operating, he pointed out; he had neither seen the blood nor handled it.

The day before the operation, Dr. Pulrang said, he had considered giving the patient the 500 cc.s as a booster in preparation for surgery. The hospital record showed that a complete blood count was done on Feb. 20. Since the blood count was within the normal range, he "de-



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One picture can be worth a thousand *dollars* in insurance recoveries, tax deductions, or liability claims. If you doubt it, just ask your family lawyer. He'll tell you it makes good legal sense to have the following photos on hand:

¶ Exterior shots of your house, office, and outbuildings. In the event of fire or other casualty loss, these "before" pictures can be contrasted with "after" shots

to establish the extent of your loss for insurance and tax purposes.

¶ Interior shots of the furnishings in every room in your house and office. These photos will help support your insurance claim in the event of a loss due to fire.

¶ Photos of anything major around your office that you're going to have repaired. If, for example, you're replacing wooden

cided not to give the blood at that time."

Nevertheless, he said later, "the next day, when the blood was offered to me during surgery, it never entered my mind that it was anything but the blood I had previously ordered and had considered giving the patient about eighteen hours before."

In commenting on the trial, Dr. Pulrang says: "It was

brought out that this operation was more extensive than anticipated and that it became necessary to remove part of the patient's bladder and reimplant the right ureter into the bladder. This slow process took at least twice as long as I had anticipated. It was my opinion, therefore, at this point in the operation, that a pint of blood would be beneficial. So when I was asked by the anesthetist if I

TO SUPPORT YOUR CLAIM?

By Allan J. Parker, LL.M.

gutters with metal ones, revenue agents may not let you take a repair deduction—unless your photos show the old gutters to be badly in need of fixing.

¶ Photos of any room in your house that you use for professional purposes. Revenue agents tend to disallow deductions for such space—unless you can prove it's actually used for professional activities.

¶ Photos of any professional

parties you give. A few candid shots of patients present—or of doctors who refer patients to you—will help support an income tax deduction for entertainment.

If there's a camera bug in your family, he or she can take all these photos for you. Then stash them away—but not in your family albums, which burn too easily. These pictures belong in your safe-deposit box. **END**

THE \$150,000 BLOOD TRANSFUSION

wanted blood now, I gave the verbal order for its administration.

"I knew that the hospital had blood prepared. It is true that I did not order it to be in the operating room at the time of the operation. In my opinion, this was quite unnecessary as it was in the bank one minute away from surgery."

But he got no backing in court from the hospital's attorney, who emphasized that the hospital's procedure required the doctor to order the blood in writing. There'd been no such written order for the Feb. 21 operation.

So the important question of whether the "captain-of-the-ship" theory of liability can be applied to surgeons in blood transfusion cases wasn't directly tested in this case. But it was introduced by the plaintiff's counsel, Emile Zola Berman, the noted New York trial attorney. Mr. Berman pointed out that other surgeons have been held liable as "captain of the ship" in other operating room cases.

And Mr. Berman read into the record this quotation from the American Hospital Association's recommendations for hospital accreditation: "The nurse-anes-

thetist is under the direction and supervision of the operating surgeon at all times."

Apparently, however, the "captain" principle hasn't yet applied in a blood transfusion situation. In one such case, not too long ago, a patient suffered serious injuries from being given the wrong type of blood. In court, the hospital was found liable for the mistake of one of its employees in typing the blood. But the doctor who had ordered the transfusion was completely cleared.

The Principle Behind It

What does it add up to? Simply this:

The attending doctor is probably in the clear if the transfusion he orders is medically indicated—and if he can prove there was no contributory negligence on his part.

What about the anesthesiologist? Well, he's obviously liable for the negligent acts of his own employees, as well as for any mistakes he himself may make in administering the blood.

Of course, any errors in blood typing or testing made in the laboratory are beyond the doctor's control. So he's not responsible

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for them. The responsibility here is the hospital's.

Even so, watch out! It's always possible that the courts may change their attitude in blood transfusion cases. More and more, they seem to be sympathizing with the plight of patients who are injured while under anesthesia. And more and more plaintiffs' attorneys are bringing suit against everybody who's in the operating room when a bad result occurs.

Most lawyers agree that doctors can expect an increasing number of blood-transfusion suits. One big reason is that hospitals in most jurisdictions are losing their traditional immunity to lawsuits. As more hospitals

are sued, more doctors will be included in the suits.

There's no easy way to stem the tide. But William F. Martin, chief legal counsel for the Medical Society of the State of New York, believes that a solid doctor-patient relationship is your best insurance against most malpractice actions. His contention: The doctor who has the patient's confidence and who explains promptly when something goes wrong—whether it's his fault or not—has the best chance of heading off trouble.

Explains Attorney Martin: "I'm convinced that the best rule any doctor can follow, when there's been an untoward result, is this: Make [More on 188]

No hero at home

It was 4 A.M. I was taking my turn at floor-pacing with my wailing 2-week-old colicky daughter, as I'd been doing half the night.

The phone rang. Holding the receiver with one hand and keeping the other firmly over my child's mouth, I gave the caller advice on his problem. I did so with considerable lack of faith in my own suggestions. I must have helped him, though, for I heard no more from him.

His problem: "Doc, what should I do? I've been up all night with my colicky baby."

—R. P. GROSCHUPP, M.D.

HOW TO RETIRE ON (no



This still-busy physician plans to combine a part-time retirement practice with a profitable investment in a growing field. Here's an appealing idea that may be feasible for you, too

Maybe the thought of eventual full retirement appalls you. But what about *partial* retirement—an arrangement that would permit you to practice a little medicine, do some administrative work, and also reap a healthy return on a financial investment?

A number of physicians are finding out that there's at least one good way to plan for such a post-65 career: While still in active practice, the doctor buys a controlling interest in a proprietary nursing home. He then becomes its part-time administrator and medical director. And

ON (not in) A NURSING HOME

BY WALLACE CROATMAN AND PEARL BARLAND

when he's ready to give up full-time practice, he can devote as much or as little time to the nursing home as he chooses.

Such a program enables the retired doctor to combine easy living with interesting medical work and a steady income. If you were sole owner of an established twenty-bed nursing home, for example, you might net as much as \$10,000 a year on your investment, plus another \$10,000 to \$15,000 in salary and fees from private patients. Yet you'd probably spend only a third as much time at this work as you put into your present practice.

Moreover, you'd be investing in an important and growing field, where skilled medical supervision is badly needed. Nursing homes for the aged and chronically ill are springing up

all over the country. Staffed almost entirely by competent nurses, they serve an increasing need of our increasingly long-lived population.

There are disadvantages to the idea, of course. It's obviously not for a doctor who doesn't like geriatric work. The initial investment might have to be large; \$30,000 is about the smallest sum for which you could hope to start a twenty-bed home. And to get the operation running smoothly, you might have to give the project a big chunk of your time for five years or more while you're still a busy private practitioner.

Even so, the men who plan to retire on—and not in—nursing homes feel that the pros far outweigh the cons. One such foresighted physician is H. L. Fahr-

HOW TO RETIRE ON (NOT IN) A NURSING HOME

ney of Frederick, Md. Now 57, Dr. Fahrney has a full-scale general practice replete with evening office hours and house calls. He's also president and major stockholder of The Vindobona, Inc., a forty-four-bed nursing home in Braddock Heights, six miles outside Frederick.

In about five years, he hopes, his son, who's now in medical school, may want to take over the practice in downtown Frederick. Dr. Fahrney will then set up a small office near Vindobona, where he'll see a few private patients and concentrate on Vindobona's administrative and medical problems. If, as he anticipates, the home runs smoothly, he'll also be able to go away for long periods of travel—something he feels he'll be able to do on his investment income from the place.

He began thinking over his retirement plans about the time he turned 50. First he toyed with the idea of buying a proprietary hospital, but the cost factor changed his mind. A nursing home seemed a reasonable substitute.

In 1953 he heard that a thirteen-acre, six-building property was for sale a few miles from his

office. The main building, erected as a summer home by a wealthy dowager, had been used for a while as a hotel. It was in poor shape. But the location—on top of a small mountain, overlooking fertile valleys—was perfect for a rest home. "Even the name—Vindobona—had a euphonious sound," Dr. Fahrney recalls.

So he decided to buy the property. It was larger than he needed—and more than he could hope to finance on his own—but there were possibilities for added income. One of the five smaller buildings was already rented to an industrial firm; another could be divided up into apartments.

How He Financed It

By selling his share in some land and getting a personal loan from a bank, the doctor raised \$50,000. He also talked some friends into investing in his projected nursing home; and a corporation was set up, with the doctor as chief stockholder. With the aid of a \$60,000 bank mortgage, the corporation bought the property for \$87,000.

That was in October, 1953. It took another eight months and

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\$30,000 to put the main building in good condition. The walls were fiberboard, and all the rooms were a dirty dark brown. There was no heat, practically no plumbing. And the house had to be furnished and equipped from scratch. "There wasn't even a light bulb in the place when we started," Dr. Fahrney says.

Two-thirds of the renovation cost went into building a kitchen in a downstairs area that had been a garage. A laundry was set up in the cellar. And private rooms were readied for twelve patients—Vindobona's original capacity.

In the year after the first patient moved in, the home averaged only five or six patients at a time; the operating deficit came to \$8,000. Then more patients began coming in, and renovation could begin on two other buildings.

Out of the Red at Last

Last year, the corporation showed its first real profit. It's now solidly in the black. The three buildings that constitute the nursing home have a capacity of forty-four patients, and ten more beds are being added. The



LOOKING AHEAD to retirement, Dr. H. L. Fahrney of Frederick, Md., has put \$100,000 into the nursing home shown on page 96. He plans to quit private practice in five years, when he'll be 62 years old.

occupancy rate averages better than 90 per cent.

Dr. Fahrney, who has been increasing his stake in the corporation right along, now has about \$100,000 invested in it (not to mention the uncounted hours he has put into organizing and expanding the venture). But he counts his money and time as well spent, not only in terms of future return but in terms of what he has already learned.

"Despite the problems of building up the physical plant, running a nursing home like ours

HOW TO RETIRE ON (NOT IN) A NURSING HOME

remains basically a question of dealing with people," observes the doctor. "I've learned a lot about how to staff a nursing home, how to handle its patients,

and how to maintain good relations with their doctors." Here's what he has found out:

The best move he's made so far, Dr. Fahrney says, was to

QUICK FACTS ABOUT NURSING

In the accompanying article, you can read about Vindobona, a home for the aged and chronically ill that's largely owned and run by Dr. H. L. Fahrney of Frederick, Md. Here are answers to some of the questions you may be asking about various aspects of financing and operating such a project:

BUILDING COSTS: They may amount to about \$5,000 a bed for land, building, and equipment. Remodeling an existing building can cost less initially, but might prove impractical in the long run.

FINANCING: Private financing is generally the best bet. Hill-Burton grants are available for nonprofit facilities only. And Hill-Burton requirements for construction are unusually high—a factor that can double building costs in some cases. The Federal Small Business Administration makes loans for nursing-home construction; but it requires 100 per cent negotiable collateral. In addition, the money must be paid back at 6 per cent interest within ten years.

PATIENT COSTS AND CHARGES: Costs per day of patient-care run about \$6 or \$7 in typical nursing homes. Typical weekly charges for regular services to paying patients: \$50 in wards, \$55-\$75 in two-bed rooms, \$65 and up in private rooms.

PROFITS: Once a nursing home is established, profits of 12 to 15 per cent of the gross income may be expected. This can amount to \$10,000 to \$15,000 a year on a twenty-bed home that provides good nursing care. Homes with fewer than twenty beds

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hire Louise Snyder as supervisor of nurses in October, 1956. He'd had to dismiss three other supervisors before Mrs. Snyder came to Vindobona.

Besides her regular nursing duties, Mrs. Snyder handles such varied chores as hiring personnel, training new employees, and keeping tabs on the home's phar-

ABOUT NURSING HOMES

aren't usually profitable unless they cut corners on services. New homes usually break even or lose money until they catch on.

INDIGENTS: Such persons may be a big problem, since most states pay lower-than-cost rates for public assistance cases. And it's not unusual for 25 to 50 per cent of the long-term patients to be on public assistance.

PERSONNEL: A forty-bed home needs about thirty-five persons on its payroll. Most of them will be R.N.s, practical nurses, or nurses' aides, in order to provide a ratio of two and one-half hours of nursing care per patient.

LICENSING AND STANDARDS: Every state requires a nursing home to be licensed and to abide by certain building standards. You'll want to check the standards before you build. Once your home is operating, you'll have to meet the state's requirements on personnel—a factor that can considerably increase operating costs.

MALPRACTICE COVERAGE: The standard contract of the National Bureau of Casualty Underwriters specifically excludes coverage for a doctor who owns or directs a nursing home. It's possible, however, to get coverage for liability in case of accident or malfeasance under another National Bureau contract.

SOURCE OF ADDITIONAL INFORMATION: Mr. Frank C. Bateman, executive director, American Nursing Home Association, 1346 Connecticut Avenue, N.W., Washington 6, D.C.

HOW TO RETIRE ON (NOT IN) A NURSING HOME

macy. "She works twelve hours a day and loves her work," Dr. Fahrney says. "We pay her \$85 a week. We recently offered her a raise and she refused it—said our finances weren't in good enough shape yet."

It takes a special type of nurse for nursing-home work, he adds. "She must have a motherly instinct. This isn't a job for a surgical nurse."

In explaining her enthusiasm for the job, Mrs. Snyder makes the same point. "To work in a nursing home," she says, "you have to like people. In a regular hospital, patients are often just cases. Here we have time to do real bedside work, and it's more interesting."

Nurses' Salaries

Two other R.N.s are on the Vindobona staff. They're paid from \$75 to \$80 a week. There are also three practical nurses (\$40-\$42) and twenty-two nurses' aides (\$32).^{*} Other personnel include two part-time R.N.s who fill in when one of the others is off duty or on vacation; a physiotherapist and a technician,

^{*}Salaries paid to Vindobona's practical nurses and aides are equal to or higher than those paid in the area's hospitals; salaries paid to Vindobona's R.N.s are higher.

who come in a few hours a week from a near-by hospital; one full-time caretaker; two full-time men in the laundry; five full-time kitchen workers; and one secretary.

Dances to Raise Funds

Most of the nurses and their aides seem to share Mrs. Snyder's delight in the work. Some spend their days off taking patients into town. The staff also run dances three or four times a year, donating the profits to the home. Once, for example, they used the proceeds to buy eight dozen sheets. And they publish a bimonthly newsletter that goes to patients, families, and doctors in the surrounding area. "It's the best advertisement we've got," Dr. Fahrney says.

Mrs. Snyder describes the nursing routine this way:

"We try to have one nursing person to each five or six patients. When a girl works closely with just a few patients, she gets to know each one better. The aged and the chronically ill appreciate a friendly atmosphere.

"For the first three days a patient is here, we carry on as though we were a hospital. We follow the [More on 212]

Investment Counselors: Prices, Pros, Cons

Their usual fees amount to hundreds of dollars a year. Can you afford it? Or, since they've put some doctors thousands of dollars ahead, can you afford NOT to hire such help?

By M. J. Goldberg

Who's the ideal person to help you with your investments? That's an easy question to answer. It should be someone who's a trained securities analyst, someone who'll watch over your holdings continuously, someone whose advice is tailored to your precise needs, someone whose only objective is serving your best interests.

The next question is a little harder to answer: Where are you going to find such a person who's priced within your means?

The type of person to turn toward is the investment counselor.

His full-time job—his only job—consists of advising other people on how to invest their money. "The emergence of this new profession of disinterested and careful investment analysts is one of the more constructive and healthy developments of the last half century," according to Bernard Baruch.

If you have surplus savings to invest but little time for supervising your holdings, an investment counselor is theoretically just what you need. Practically, though, you're up against the hard fact that such personal in-

INVESTMENT COUNSELORS: PRICES, PROS, CONS

vestment advice costs money—a goodly slice of it. Would the expense be worthwhile in your situation?

To answer that, let's consider first what a counselor is and what he can do for you. Let's compare his help with investment help you can get from other sources. Then you can judge how the cost of his services measures up against your potential gain.

He Sells Only Advice

Basically, an investment counselor is quite like a lawyer. His advice is direct, personal, unbiased, and confidential. He has no stocks to sell; he makes no commissions. You pay him the same fee no matter which securities you buy, no matter where you buy them, no matter how often you buy and sell.

What does he do for this fee?

If you go to an investment counselor, his first step will probably be to take a long, hard look at you. He'll ask how old you are, what your income is and how steady it is, how much insurance you carry, the number of your dependents and their ages, when you plan to retire and where. He'll ask how your investments have progressed so far, where

they stand today, and what you hope to achieve in the future.

"A good investment counselor studies his clients as much as he studies their securities," says L. O. Hooper, respected *Forbes Magazine* columnist. "The very issue which should be sold in one investor's account often should be bought in another."

After the counselor knows your situation, he'll suggest a long-range program to meet your objectives. And he'll tell you specifically which securities should be bought and sold to launch that program.

If you want, the counselor will merely give you his recommendations, and you can place the buy and sell orders yourself. Or you can give him authority to place the orders for you.

You Keep Control

Either way, the counselor doesn't usually hold your securities, and he gets no share of the brokerage commission. You retain full control over your account. You can modify it whenever you want. And you can drop the entire arrangement with him at any time.

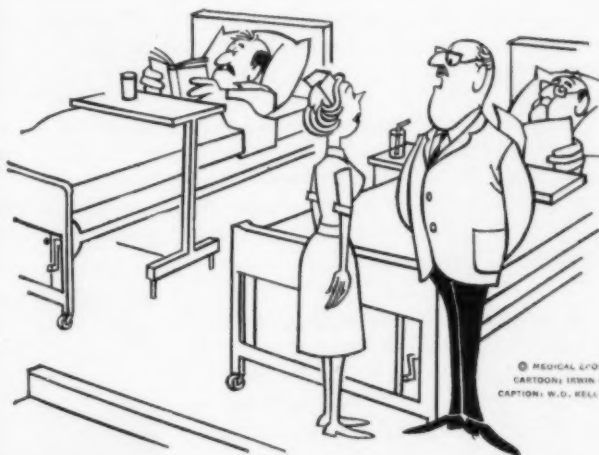
Once every three or six months, he'll send you a detailed

accounting of your holdings. During the interim, of course, he's continually studying the securities you hold and possible replacements for them. If he believes one of your holdings is turning sour, he'll notify you immediately and recommend a switch.

One thing he *won't* do is recommend week-to-week switches. By nature, investment counselors are rarely speculators. They're interested in the long pull. Many, in fact, refuse to handle accounts for short-term trading.

"We recommend a stock to a client because we consider it a good long-range investment for him," says Howard F. Wortham, president of the New York counseling firm of Trainer, Wortham & Co. "We advise sale only when we believe his money can be put to better use elsewhere."

A counselor will also keep an eye out for your tax problems. He'll make sure that transactions are timed for the biggest tax break. Naturally, the size of your tax bracket will strongly influence his choice of securities for you. *More▶*



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CARTOON: IRWIN CAPLAN
CAPTION: W.D. KELLY, M.D.

"'Potty' and 'tinkle' may be all right on Pediatrics, Miss Tait, but . . ."

INVESTMENT COUNSELORS: PRICES, PROS, CONS

As you can see, the only thing an investment counselor has to sell is advice. That's something that everybody and his brother will gladly give you for nothing.

So why should you pay good money for it?

Why not depend upon your broker's free assistance? Or why not spend a few dollars for a

Six Investment Counselors

Thirty years ago, there was almost no such thing as an investment counselor—a man whose full-time job is to advise others on how to handle their money. Now you can find such counselors in almost any large city. The emergence of this new profession, says Bernard Baruch, "is one of the more constructive and healthy developments of the last half century."

Some counselors are independent consultants; some are affiliated with banks, investment publications, or mutual funds. Here's a pictorial cross-section of the field. The six counselors pictured here aren't necessarily the best ones for you; they've been selected to show the scope and variety of available counseling service.



INDEPENDENT COUNSELOR is Howard F. Wortham, president of New York's Trainer, Wortham & Company. His Rx for most individual investors: growth stocks. Smallest account his firm will customarily handle is \$25,000.

FUND ADVISER: Mutual funds use outside investment help at times, and many turn to private counselors for it. The Boston-based firm of David L. Babson helps direct the fortunes of the Aberdeen Fund.



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subscription to one of those investment advisory publications? Or why not get professional investment help simply by investing your money in mutual funds?

Let's see how an investment counselor compares with those other kinds of investment aid:

A broker's advice is often expert, often personal, often con-

BANKER-COUNSELOR: Investment management service is a specialty of New York's U.S. Trust Company. Executive vice president Charles W. Buek is in charge of personal investment accounts.



PIONEER COUNSELOR: One of the first investment counselors was A. Vere Shaw. The New York firm bearing his name dates back to 1926. Mr. Shaw became the first secretary of the Investment Counsel Association.

AFFILIATED ADVISER: D'Arcy Parrott of New York heads the Forbes subsidiary specializing in personal investment counseling. Mr. Parrott's service is aimed at the man with \$50,000 and up to invest.



WESTERN COUNSELOR is W. Murray Hawkins. His long-established Los Angeles firm, Koenig, Hawkins & Titus, numbers among its clients pension funds, a hospital, and a college, as well as individual investors.

INVESTMENT COUNSELORS: PRICES, PROS, CONS

tinuous. But a broker earns nothing by giving you information. He makes his money by collecting commissions when you buy and sell.

"There's considerable doubt whether any advice can be unbiased if the adviser has a financial interest in whether you take his advice or not," says Howard Wortham.

As another investment counselor puts it: "Perhaps asking a

broker if you should switch stocks is a little like asking an automobile dealer if you need a new car."

As for investment advisory letters, they're normally unbiased. Many of them are excellent sources of information. And they usually back up their recommendations with thorough research.*

*See "The Truth About Investment Advisory Letters," MEDICAL ECONOMICS, June 8, 1959.

HOW I DICTATE WHEN

This doctor saves many hours a month by doing essential paper work at the



I had 14-month-old Danny Adams admitted to St. Mary's Hospital today. Danny is suffering from repeated attacks of diarrhea and respiratory infections. For most doctors, this might mean spending a good half hour reciting the patient's history into the hospital's dictating machine.

But not for me. In fact, recording Danny's condition took less than a minute.

THE AUTHOR is a pediatrician in Palm Beach, Fla.

The trouble with advisory letters is that they aren't personal. The editor doesn't know what stocks you already own, what you paid for them, or what your investment objectives are. If your objectives change, he can't recommend the specific switches that may be best for you.

"After all," remarks one investment counselor, "a doctor wouldn't send out a weekly bulletin to all his patients advising

them to switch from penicillin to streptomycin. But that, in effect, is just what these advisory letters do."

How about letting a mutual fund do the investment counselor's job? There's not much doubt that the managements of the leading mutual funds are competent and unbiased and that they continually supervise their investments. Also, you should have little trouble [*More on 224*]

TE WHILE DRIVING

BY GOVERNOR WITT, M.D.

at the wheel of his car. Big-city drivers can't do it, but others can

How come? It was easy. While driving to St. Mary's, I dictated Danny's history into the portable 3-pound tape recorder I keep beside me in my car. At the hospital, I set up my recorder to play back the tape into the hospital's dictating equipment. Then, while my machine was talking to the hospital's machine, I made evening rounds. Afterward, it took me just thirty seconds to add my current findings to the hospital record. And then—recorder in

hand—I was off to a house call.

I use the recorder while making house calls too. For example, while driving back to my office, I dictated this about 3-year-old Mary Jo Barker: "Tonsillitis, temperature 103, cervical glands. Penicillin injection and penicillin P.O. To come to office Tuesday afternoon for a shot. Bill for routine house call and shot."

Back in the office, I handed the recorder to my aide. Without my having to say a word, my

HOW I DICTATE WHILE DRIVING

aide knew (1) what to transcribe on Mary Jo's case history card; (2) what time to schedule for me to see the patient again; and (3) how to handle my fee for the visit just completed.

It's a Real Time-Saver

I save about twelve hours a month in this way. Previously—before I put to use the dead time in my car—I was plagued by a backlog of patients' records. Bringing them up to date robbed me of my free time. I spent half my days off on routine paper work.

The problem came to a head during the 1957-58 Asian flu epidemic. Like most doctors, I was overwhelmed by the flood of flu victims. I was spending all my waking hours either seeing patients or filling out records. All at once I found myself *forty* charts behind. That's when I said to myself, "You've got to do something!"

7 Pieces of Equipment

So I did. I worked out my present tape-recorder system. What does the system include? Well, it has seven basic parts:

1. THE RECORDER. I bought a Mohawk Midgetape Chief (Mod-

el 400) because it could work either from a wall plug or on a replaceable mercury battery. With a tape cartridge, twelve-hour battery, and microphone, the Mohawk unit cost me \$320.

2. THE SPEAKER. The unit's microphone doubled as its speaker. But I found that the sound coming out of the mike wasn't clear enough. So for \$35 I bought a transistorized amplifier-speaker. This enables me to play back my dictation without a separate amplifier.

90-Minute Tapes

3. TAPE CARTRIDGES. The tape cartridge that came with the unit was good for only sixty minutes of recording. I decided a ninety-minute tape would serve me better. So for \$2 more I traded the original cartridge in for the long-playing kind. And I stocked up on extra tape cartridges at \$13.50 apiece.

4. HOOK-UP CORDS. From the first, I was hit by a multiplicity of recorder makes. I have a Dictaphone in my office. Good Samaritan Hospital has a Gray Audiograph; and St. Mary's has a SoundScriber. Without special hook-up cords, my Mohawk couldn't speak to [More on 238]

It's no secret that surprising numbers of pediatricians love medicine but hate pediatrics. A few years ago, in a study of the six largest specialties, MEDICAL ECONOMICS found that pediatricians were among the most satisfied with medicine as a career. But more than a third of them said flatly they wouldn't pick their specialty again.

Since then, the specialty has grown fast—and so have its frustrations. Many of them are apparently spelled M-O-T-H-E-R. That, at least, is the word used most often by some 300 newly surveyed pediatricians in explaining their mixed feelings toward their life's work.

"To enjoy pediatrics," says one Easterner, "you've got to love medicine and be crazy about children. Otherwise, you wouldn't be able to put up with the things their mothers do to you."

What sort of things are getting some pediatricians down? Those surveyed by this magazine cite three main frustrations:

1. Because many mothers are overanxious, the pediatrician is

'MEDICINE'S MOST FRUSTRATING SPECIALTY'

Working with children is fine, say these surveyed pediatricians—but oh, those parents! Here's an inside look at what seems to be wrong with the specialty today. Setting it right may involve you

By Clifford F. Taylor



'MEDICINE'S MOST FRUSTRATING SPECIALTY'

often bowed down by unnecessary telephone calls, house calls, and night calls.

"I took forty phone calls at home last Sunday," reports a Los Angeles man. "Typically, only three of the children involved were sick."

Some other pediatricians report that during a working day, sixty to 100 phone calls are more the rule than the exception.

Not all the calls are from mothers, of course. A San Francisco doctor comments: "Pediatrics would be a wonderful specialty if it could be limited to children. It's the parents, grandparents, other relatives, and oversolicitous friends who make my daily phone hour rough. Usually it stretches out to two or three hours—and leads to many unavoidable but unnecessary house calls."

2. Because he gives so much routine service, the pediatrician often isn't regarded as a skilled specialist.

Parents and even some pediatricians themselves indicate as much. "The practice of preventive pediatrics is necessary," says a Texas doctor, "but it isn't very interesting or highly skilled. Nor is the treatment of coughs and

colds—which comprises about 90 per cent of most pediatric practices."

And an Illinois man comments: "Whooping cough vaccine saves more lives than all the appendectomies. But a nurse can give it as well as any specialist."

In the eyes of the parents, many surveyed men say, they're regarded as "baby G.P.s" rather than as specialists. Adds a doctor in Birmingham, Ala.:

"You've really had it when the anxious mother looks at you and asks: 'Do you think Joey's sick enough to call in a regular doctor?'"

3. The pediatrician's hours often are too long and his earnings too low.

"I see more patients, work longer, and have more irregular hours than any other doctor in the community," says a New Jersey man. "I do this to produce an income lower than that of most local G.P.s."

Adds a Missouri doctor: "I do the well-baby clinics, the polio clinics, and the school clinics—all for free. Even in my own practice, many young parents can't afford my modest fees."

"I've got to keep up a produc-

tion-line practice to make an adequate living," says a doctor in Houston, Tex. "The older I get, the harder it is to do."

A Pennsylvania pediatrician puts it this way: "People seem to

feel that if children pay half prices on trains, at movies, and so on, they should get half-price medical care. Our fees aren't consistent with the time spent on our practices." *More►*

WHAT FUTURE FOR PEDIATRICS?

Pediatric leaders are well aware of the discontent described here. They blame it on too rapid growth of the specialty in numbers, on pediatric training too remote from the realities of practice, and on young M.D.s' misconceptions about pediatrics.

What is the pediatrician's proper role? Leaders in that specialty have been working out the answer. But since other doctors will be affected, other doctors may want to work out the answer too. The accompanying article should stimulate them to do so. That, in fact, is its underlying purpose.

"Pediatrics has never been a specialty in the strict sense," says Dr. Wyman C. C. Cole Sr., chairman of the A.M.A. Section on Pediatrics. "It is general practice confined to an age group."

If pediatrics is really general practice, the principles of general practice management—the same ones expounded in almost every issue of *MEDICAL ECONOMICS*—should be the salvation of solo pediatricians. But something else is necessary too: a state of mind. Listen again to Dr. Cole:

Those who find pediatrics monotonous and boring are practicing with their eyes shut . . . Of the thousands of times I have discussed with a young mother her perfectly normal baby, I have never once found it boring. She may have memorized Dr. Spock's excellent book from cover to cover, but she needs something more . . . It is very gratifying to feel that you are giving this girl confidence and starting a new family off in the right direction. It is not as dramatic as a cardiac catheterization, but it is more basic and in the long run more important."

The future of pediatrics depends on that state of mind.

'MEDICINE'S MOST FRUSTRATING SPECIALTY'

In view of the long hours, the low pay, the house calls, the phone calls, the thoughtless parents, and the scarcity of interesting and challenging cases, what satisfactions *are* there to the practice of pediatrics?

The answer, from satisfied and dissatisfied pediatricians alike, can be put in one word: CHILDREN. To pick a few remarks at random:

"Children have few psychosomatic complaints" . . . "Children are quick to forgive and forget" . . . "Children aren't hypochondriacs, drunks, or dope addicts" . . . "Children are growing, not deteriorating" . . . "Children are fascinating."

A Washington, D.C., doctor sums up the case for pediatrics in these six words: "Children are cheerful. Children get well."

If pediatricians could feel as happy with the other aspects of their practice as they do with their patients, their discontent would doubtless disappear. This is exactly what has happened in the case of a number of the surveyed doctors. They've apparently found a solution to their problems in some form of combined practice.

"I'd never practice pediatrics

again on a solo basis, as I did the first five years," says a Columbus, Ohio, doctor. "Now, with an associate, I have every other night and every other week-end to myself. Life has become bearable again."

Much the same story comes from an Iowa man: "I'm in a group of four pediatricians. We have definite time off each week, ample vacations, and a pleasant professional life. If I'd continued in solo practice, I doubt if I'd have lived this long!"

No More Frustration

Adds a South Carolina doctor: "My two and a half years in solo practice were most frustrating. The demands on my time were so great I was ready to give up pediatrics. Now I practice in a four-man pediatric group, and it's the difference between night and day. I earn a better income, am no longer overworked, and have a reasonable amount of time off."

Can partnership or group practice solve *all* the pediatrician's problems? Not as some men see it. Observes an Illinois practitioner:

"If a man devotes two years to acquiring a highly specialized

skill, and then enters a practice that for 90 per cent of the time doesn't require this skill, he hasn't much hope of finding full professional satisfaction."

What, then, is the answer? There's no single or simple one. But leaders in the field of pediatrics have recently been discussing the possibility of taking one or more of the following steps:

¶ Let G.P.s handle routine pediatric problems. The pediatrician might then become a true specialist—i.e., a consultant on only the more important diseases and disorders of childhood.

¶ The pediatricians might campaign to educate parents to recognize—and pay for—specialized skill in pediatrics.

¶ The pediatricians might campaign within the profession to establish pediatrics more firmly

as one of the most important fields in medicine.

Many thoughtful pediatricians say that a combination of all three measures is long overdue. But even the most optimistic of them doesn't contend that there's an easy road ahead.

Meanwhile, there are many things the individual pediatrician can do to better his lot. An Arkansas doctor points the way:

"For five years I let my practice run me. Now I run *it*. I've irritated some patients, even lost some. But my new policy seems to have paid off. I make the parents take care of the kids when they're well. I take care of them only when they're sick. My practice is more interesting, my income hasn't suffered, and I've begun to live like a human being."

END

Woman's prerogative

I paced up and down outside the delivery room, awaiting my first-born. Suddenly the room rang with mirth. Under the influence of gas, my wife had exclaimed a moment before the baby arrived: "Honey, let's call the whole thing off and go home!"

—IRVING L. ROSEN, M.D.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS pays \$25 to \$40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.

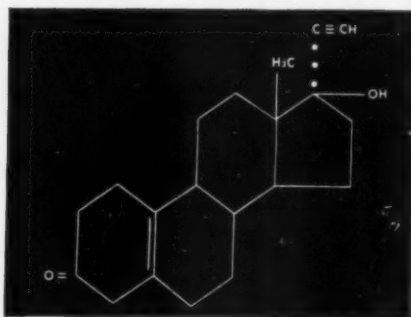
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Thus, its administration is free of risks of virilism even on long-term administration at high dosage. Each 10-mg. tablet of Enovid contains 9.85 mg. of norethynodrel and 0.15 mg. of ethynylestradiol 3-methyl ether. (-The estrogen is added in optimal amount to avoid breakthrough bleeding during prolonged use.-)

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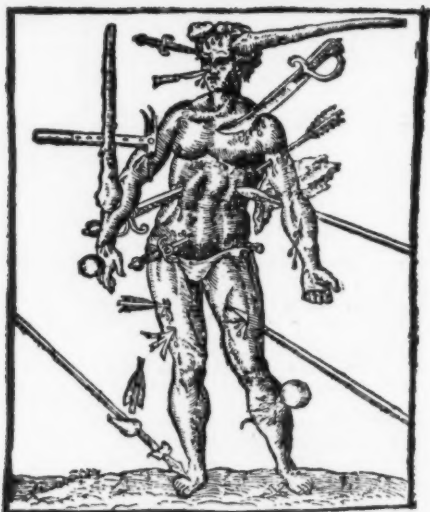
The daily dose for the first two weeks is one tablet, two tablets daily for the next two weeks, then three tablets daily for the following two weeks and finally four tablets daily for three to nine months.

G. D. SEARLE & CO., Chicago 80, Illinois
Research in the Service of Medicine.

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How I've Profited by Cutting Back My Practice



Is it possible to reduce working hours sharply without ruining a practice? Here's evidence that the answer is yes. This doctor used to work eighty hours a week. Now he works thirty hours—and earns more than before

By F. H. Halley, M.D.

Not long ago, I was in the New York Academy of Medicine library. I'd just made a request for some of the literature on smallpox virus and cancer. Suddenly a half-familiar voice said: "What's up, Doctor? One of your patients *can't* have smallpox." I turned and recognized a colleague I hadn't seen in years.

I laughed. "Oh, no, George, nothing like that," I said. "It's just that I've got an idea there's

some connection between the virus and cancer. I'd like to check on what's been written about it. It happens to be a pet theory of mine, and—"

George broke in before I could finish the sentence: "You mean to say you're just poking around? How can you spare the time from that practice of yours?"

I laughed again. "You're behind the times, George," I said. "I practice only thirty hours a

THE AUTHOR, a New York G.P., writes here under a pen name.

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I'VE PROFITED BY CUTTING BACK MY PRACTICE

week these days. The rest of the time, I do as I like."

My friend looked startled—and a bit envious. "How do you manage that trick?" he asked.

So many doctors have asked me the same question that I've come to realize how deeply concerned most of us are about the problem of overwork. That's why I've decided to write down my story. It may help some of you do what I've done. It may help you do it *voluntarily*—unlike me.

Ill health forced me to cut

back my practice from eighty to thirty hours a week. But for several years now I've felt fine; and I haven't had the slightest desire to return to the old back-breaking routine. My only regret is that I didn't slow down before I had to.

I started thinking about a slowdown on the day when a former classmate of mine died. He'd built up a busy practice, just as I had. We both practiced in that teeming part of New York that makes up the Bronx. Not that I believe the Bronx makes



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heavier demands than any other big-city area in the country. All such places keep you stepping, if you let them.

My former classmate worked too hard. He was well under 40 when he died of hypertension. I was just about his age.

Naturally, his death made me wonder what I might be doing to myself by running around all day to three hospitals and rushing off half the night on house calls. I thought of possible ways to cut down. But I did nothing about it at the time.

Forced to Slow Down

Some years later, the blow fell. On a late-night house call, I suddenly blacked out in the hallway of a strange apartment house. I won't bore you with the details. It's enough to say I spent six weeks in the hospital, with a lung and coronary condition.

Now I had plenty of time to do some thinking. I looked back over the twelve years I'd been in practice and asked myself a few searching questions.

What had I built up? I had staff appointments at three good hospitals. I had office hours every afternoon and every evening. I was on tap twenty-four hours

a day. And I never refused to make a house call.

My net income before taxes was about \$16,000—which wasn't bad a few years ago. But even if I'd been earning a lot more, I'd still have been poorly compensated for my toil.

Obviously, I couldn't go on as before. But how, I wondered, could I cut down drastically and still maintain a practice? I finally decided to let nature take its course. I wouldn't try to do any more than I could do easily.

Fortunately, we had a house in the country, about twenty miles from New York City. We'd kept it mostly as a summer home. But when I was able to leave the hospital, I moved there with my wife and three children. At the same time, I determined neither to close my city office nor give up my city home.

Minimal Office Hours

The first months of my convalescence happened to be July and August. So I worked out a modest schedule. I decided to spend Monday through Wednesday in the city and to open the office for patients at noon. Each day, I'd close at 3 P.M. Then each Wednesday afternoon, I'd

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1. Shoyan, A.: J.A.M.A. 188: 147, Sept. 13, 1958. 2. Folker, H.L. and Kassel, L.E.: Antibiotic Med. & Clin. Therapy, 3:322, 1956.



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take the train back to the country, where I'd spend four days resting.

It worked out pretty well. Old patients gradually started coming back. New ones dropped in. My medical friends also rallied round: They offered to cover for me whenever I wasn't available.

That's the way it started. By fall I had a fixed routine. Then I added something new: Instead of expanding my city practice, I opened a new office in the country. (It's attached to my house, and the overhead is minimal—partly because I sublet it part-time to an ophthalmologist.) Thus I set the pattern for my future professional life. And I've stuck to it.

The routine in both offices is exactly the same—and has been for a number of years. I have office hours from 11:30 A.M. to 3:30 P.M. three days a week in each place. I make absolutely no house calls. But I do minor surgery in my office—and sometimes at the hospital—during the mornings when I'm in the city. Including everything, I now average about thirty hours of work a week.

This isn't intended as a semi-retirement schedule. For me, it's

a full-time practice. And it's just right! I'm healthy and strong these days. I intend to stay that way.

How has my limited practice worked out financially? I've been astounded. Even though I'm averaging only thirty hours a week in two offices twenty miles apart, I find that I'm earning more than I did in the old days. Last year, my net income before taxes was around \$20,000.

How come? One reason, of course, is that all of us are more prosperous than we used to be. A better reason is that I've taken several steps that I think might interest you (though I don't presume to set them down as *rules* for cutting back a practice). For example:

First of all, I set about increasing the efficiency of my office routine.

At the very beginning, I selected a capable professional nurse to assist me in both offices. Then I trained her in my way of doing things. I trained her to take preliminary histories, do blood tests, run off ECGs, give injections, and so on. By the time I now see a patient, much of the routine work has been completed.

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It's the same in surgery. Either in my office or in the hospital, everything is prepared before I arrive. The schedule is worked out almost to the minute. I step in, do my job, and then step out again.

Of course I'm available if any difficulty arises. Otherwise, the nurse never interrupts me.

Next, I've lined up several young doctors who willingly cover for me in my off-hours.

As soon as I'd decided to keep my practice limited even though my health had returned, I stopped imposing on friends. Instead, I made an arrangement with some young doctors who were glad to have more practice. They agreed to accept calls from my patients when I wasn't available.

The men who now cover for me in both New York and the country charge what they normally charge their own patients. Naturally, no money passes between us. But the arrangement is quite formal. And although a few of my old patients have switched to the new men, most have stayed with me.

Some such covering arrangement is the key to cutting back a practice. It can't be done other-

wise. Yet it's not impractical anywhere in the country. Professional management men tell me that in most communities outside of strictly rural areas, beginners are generally eager to pick up extra work by covering for older men.

Finally, I've raised my fees about 25 per cent.

I took this step a few years ago—as soon as I felt confident that my patients were getting more for their money as a result of my increased efficiency.

For one thing, I'd eliminated the extra expense of house calls; patients were actually saving money through being educated into coming to the office *in time* instead of waiting for off-hours emergencies. Then, too, I was much more relaxed in the office. I found I was giving the patient a sense of not being hurried, of having everything possible done for him when he was in my hands.

Almost immediately, I learned two things. First, patients appreciate having your full attention. They're actually eager to pay more for individual and personalized service. And they tell their friends about it. Secondly, I myself became convinced I was

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practicing much better medicine than before.

Looking back, I suspect that one of the important factors in my success is that having once set up a limited schedule, I stuck to it. I've discovered that patients will accept the limitations a doctor sets on his practice. All it takes is a bit of training.

Eliminating house calls created a problem at first. For example, my patients were used to phoning and having me respond. Now they listened a little impatiently when I explained my no-house-call policy. "But Jackie

has a very high temperature. I can't possibly bring him out," an occasional mother would protest.

Explaining the New Rule

Then I'd explain that a high temperature wasn't necessarily a dangerous symptom, and that I could look after the boy better in my office, where I had all the necessary equipment. I'd also point out that even for the patient with a high temperature, there'd be much less waiting time in the office, where I could see him right away. *More▶*



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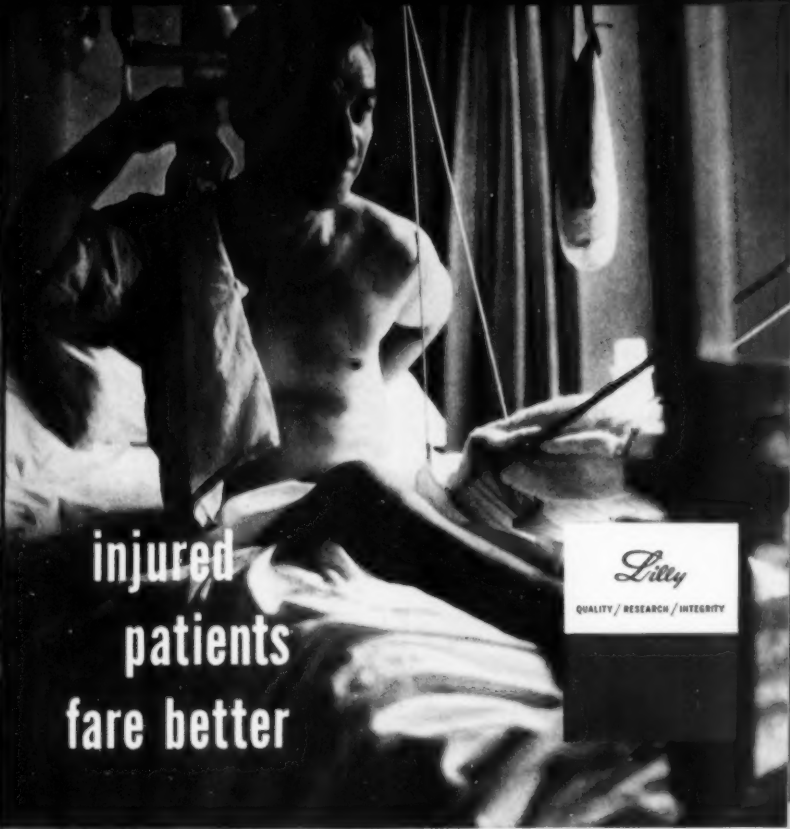
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1. Hayes, M. A.: Water-Soluble Vitamin Requirements in Surgical Convalescence, *Ann. Surg.*, 140:661, 1954.

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1. Summary of extended clinical trial data, Lilly Laboratory for Clinical Research.
2. Rhode Island M. J., 40:514, 1957. 3. Geriatrics, 12:607, 1957. 4. Illinois M. J., 112:273, 1957. 5. Am. Pract. & Digest Treat., 9:397, 1958.

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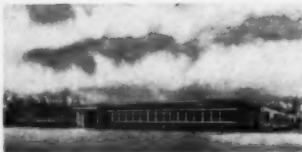
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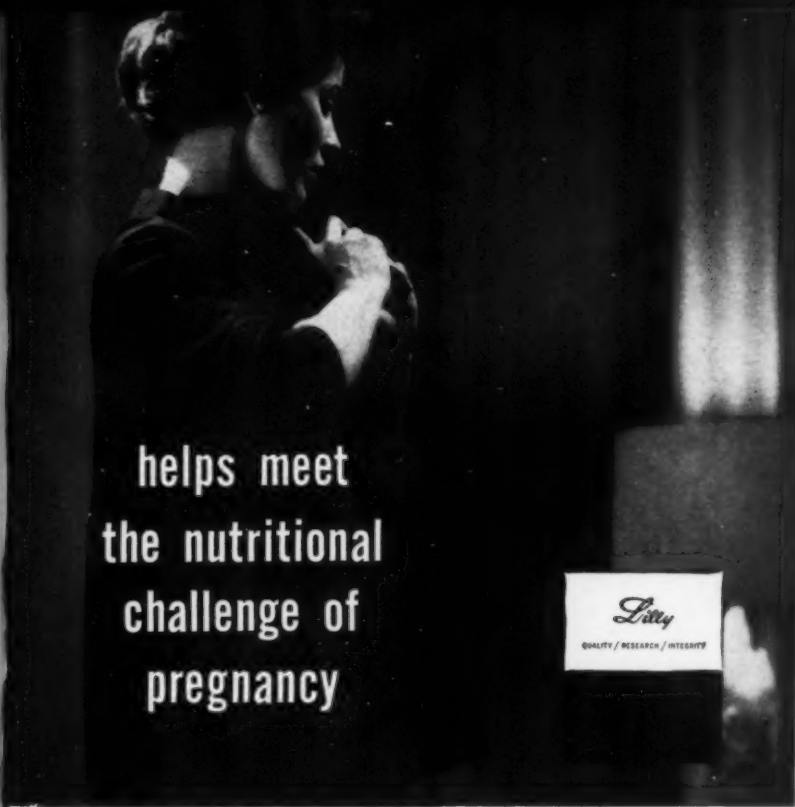
People in general soon learned that what I said makes sense. They still call me when they're really worried, of course. And if I think it advisable, I naturally ask one of my young colleagues to see the patient.

The Model Husband

By now, it's a rare patient who doesn't accept the fact that I no longer make house calls. As for me, I'm a healthy, happy man. And I'm a *family* man. Once, years ago, when I'd been at the hospital for two nights running on emergency surgery cases, my wife stuck a wry sign on the bedroom door: "Bed For Rent!" She has since thrown the sign away because it no longer makes sense.

I've time now for medical interests I've always wanted to pursue. I can read up on the cancer literature. I can try out some of my pet theories. I've even written a couple of articles for the New York State Journal of Medicine.

Too many doctors are rich in money but poor in time. Maybe my story will influence some of them to strike a happy medium. Cutting back a practice isn't easy, but it can be done. And the profits can be measured in more than dollars. END.



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By Wilfred Snodgrass, M.D.

When one of your hospital patients says, "They gave me a shot," or "They gave me a sleeping pill last night"—take care! He may feel that you've bowed out of the picture.

His fear is baseless, to be sure. But it's a notion that's easy for a bedridden hospital patient to come by.

True enough, the many persons besides yourself who contribute to the patient's care are



acting on your orders. Yet if your patient is like many of my own, he feels that the comings and goings of hospital employes are no substitute for your own approach to his bedside. He yearns for tangible signs that his personal physician is close at hand—that "you," not "they," are still in charge.

Well and good. But how can we manage to give each of our hospital patients all the personal

THE AUTHOR is a general practitioner who practices in Santa Monica, Calif.

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1. A. M. A. Arch. Int. Med., 99:346, 1957.

2. Am. J. Obst. & Gynec., 70:1309, 1955.

3. Lancet, 1:448, 1957.

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DO YOUR HOSPITAL VISITS REALLY HELP?

attention we'd like, when most of us have only minutes to spend with them?

The secret, I think, is to make every minute mean the most in personalized care. Thus:

1. Before the patient goes to the hospital, I reassure him by stressing that the trip is an extension of my treatment.

One of the patient's chief questions at this point, I've found, is likely to be: "Why can't you take care of me at home?" I explain why I can't. And I talk in terms of our continuing relationship: "In the hospital I'll be able to do thus and such for you"—the "I" being much more reassuring than the impersonal "they."

Right then I also try to tell my patient something else he's sure to wonder about: how long he's likely to be in the hospital. And I make a mental note to give him a more definite time estimate as soon as I can.

What if this talking-over in advance isn't possible? What if a patient needs to be rushed to the hospital in an emergency?

Even then, I get in touch with him or his family by telephone while the ambulance is on the way to the house. A few words

from me can start the patient off to the hospital with the assurance that his doctor is still with him, in a real sense.

2. Soon after admission, I visit the patient and talk over what's ahead for him—"my" hospital procedures—in considerable detail.

Probably what he expects in the hospital—and dreads—is that he'll be pushed, pulled, and poked by a large, anonymous staff: "they." So I myself tell him what's in store for him.

I don't think it's enough for the doctor to paint a general picture. To the worried patient, every detail of his future is intensely interesting. That's why I supply a preview of as many details as the patient can assimilate. For example, he's much less likely to be apprehensive about spinal tap, blood count, X-rays, or whatnot if he hears about them first from his own doctor.

I'll even try to fill him in on routine matters—and especially those he might resent if they were first sprung on him by a nurse or another hospital employee. For example, I may explain that I've ordered absolute bed rest and that therefore he'll need to ask for a bedpan. I may

relief
from
the acute pain
of
trauma



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The clinical usefulness of Darvon® (dextro propoxyphene hydrochloride, Lilly), alone and in combination, has been substantiated by more than 100 investigators in the treatment of over 6,300 patients in pain. A consolidation of these reports shows that 5,663 (89.8 percent) experienced "effective analgesia."

Darvon Compound combines in a single Pulvule® the analgesic action of Darvon with the antipyretic and anti-inflammatory benefits of A.S.A.® Compound (acetylsalicylic acid and acetophenetidin compound, Lilly). When inflammation is present, Darvon Compound reduces discomfort to a greater extent than does either analgesic given alone.

Usual dosage: 1 or 2 Pulvules three or four times daily.

Also available: Darvon, in 32 and 65-mg. Pulvules.

Usual dosage: 32 mg. (approximately 1/2 grain) every four hours or 65 mg. (1 grain) every six hours.

Darvon® Compound (dextro propoxyphene and acetylsalicylic acid compound, Lilly)

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DO YOUR HOSPITAL VISITS REALLY HELP?

talk about diet, too: I'm arranging for him to have so-and-so to eat, for such-and-such reasons.

3. On my daily follow-up visits during a patient's stay, I'm ready to act as mediator between him and the hospital.

Why am I needed as a mediator? Luckily, I'm usually not. But every now and then a bed-ridden patient ruminates over the inevitable small irritations of his hospital routine, until they become real gripes.

So I'll ask a patient, "Are

things going smoothly?" And I'll show by the way I say it and by my expectant attitude that I'm not simply being polite; I really want to know if he's comfortable.

The patient's reply often brings to light some minor annoyance he has been brooding about. Once he gets it off his chest, he feels better. Perhaps I can take care of his complaint myself. If not, I may diplomatically take it up with the nursing or the house staff. *More▶*



"Maybe it doesn't hurt *them* . . . But it sure kills a lot of rabbits."

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controls hypertension



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SANDRIL® c̄ PYRONIL® adds antihistamine to reserpine therapy

Although the nasal stuffiness commonly caused by reserpine preparations is seldom serious, it may be bothersome enough to induce patients to cease therapy.¹

Clinical experience^{1,2} has revealed that the antihistamine, Pyronil, provides relief for approximately 75 percent of patients who experience this side-effect. Therefore, Sandril c̄ Pyronil offers you better patient control by providing greater freedom from nasal congestion.

Each tablet combines:

Sandril 0.25 mg.
Pyronil 7.5 mg.

Usual Dosage: 1 tablet b.i.d.

Sandril® (reserpine, Lilly)

Also: Sandril, as tablets of 0.1, 0.25, and 1 mg., and elixir, 0.25 mg. per 5-cc. teaspoonful.

1. *Geriatrics*, 12:185, 1957.

2. *J. Indiana M.A.*, 48:603, 1955.

Pyronil® (pyrrobutamine, Lilly)

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971008

DO YOUR HOSPITAL VISITS REALLY HELP?

While I'm at it, I try to hit upon some small change in hospital routine that may add to my patient's comfort. For example, I sometimes recommend a change in the way a bed or a table is adjusted. It's a small gesture, but it tells the patient what he wants to know: that I'm as alert to his welfare there in the hospital as I would be in my office or at his home.

4. Just before or after the patient is discharged, I interpret the results of his treatment to him—in a way that starts him thinking where we go from here.

Usually, I've found, it's not enough for the physician to say, "Everything has turned out all right." After spending days in bed, the patient wants to know just what is all right—and how much so.

Even negative laboratory findings are worth talking about. The patient is usually glad to hear that "there was no albumin in the urine" (or "no trace of sugar"). And a doctor who recites such details indicates that he's been closely following the patient's hospitalization.

But I make these details lead

never any compromise with quality

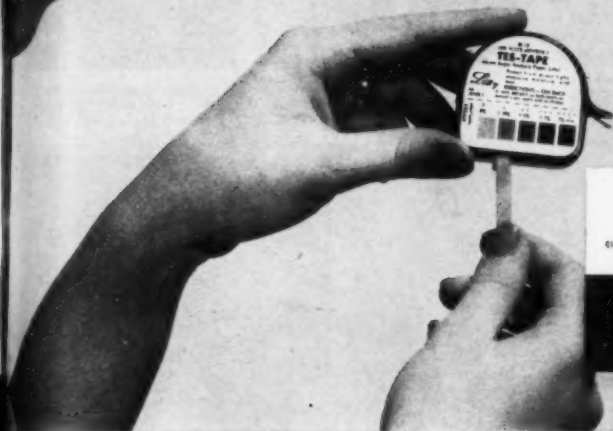


May Ophthalmoscope and Arc-Vue Otoscope with the luxury look-and-feel. Brilliant illumination, superlative optics. Bayonet lock, nylon specula, lifetime satin-finish aluminum. Choice of battery handles. Sleek pocket case.

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to safeguard
the fetus



TES-TAPE® . . . helps detect the pregnant "pre-diabetic"

" . . . fetal mortality in the unrecognized diabetic may be as great as, if not greater than, in the known diabetic."¹ Therefore, it is vital to find the "pre-diabetics" by frequent blood and urine testing.

Because of its greater sensitivity and specificity, the glucose oxidase (Tes-Tape) method of urine glucose determination has been recommended^{2,3} for use during pregnancy in preference to copper-reducing methods. Fructose, galactose, and lactose in the urine of pregnant women give false positive reactions with copper-reduction tests.

These sugars will not affect Tes-Tape, however; Tes-Tape is specific for glucose. Moreover, because Tes-Tape is more sensitive, it detects even minute quantities of glucose. Thus, you can discover the glycosuria earlier and institute further studies and corrective measures more promptly.

1. Shlevin, E. L.: *Pregnancy and Diabetes*, Diabetes, 6:523, 1957.

2. Wilkerson, H. L. C.: *Ibid.*

3. Whitehouse, F. W., et al.: *Management of the Pregnant Diabetic*, M. Times, 86:833, 1958.

Tes-Tape® (urine sugar analysis paper, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

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ONE PITCH AND I STRUCK OUT...



Just an hour of pitching baseball with my son and I "threw my arm out." Painful! I couldn't even sleep that night!



Next day on the job I was a total loss — could hardly lift a slide rule!



I saw my doctor that night and got a prescription for some tablets.

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AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each **Percodan**® Tablet contains 4.50 mg. dihydrohydroxycodone hydrochloride, 0.30 mg. dihydrohydroxycodone terephthalate, 0.30 mg. homotropine terephthalate, 224 mg. acetylsalicylic acid, 100 mg. phenacetin, and 32 mg. caffeine.

70-6, 70-5, 70-6, 70-7



Amazing! The pain went away fast — in about 15 minutes. I slept like a baby. Finished my design for the new warehouse next day, and not a bit of trouble since!

AND THE PAIN WENT AWAY FAST

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HOSPITAL VISITS

directly to some clear conclusions and recommendations. For they're what the patient needs most as he returns to life outside the hospital.

There you have my own four-stage program for handling patients in the hospital. But why do I pay so much attention to such brief encounters?

Because they *are* so brief. Nearly everyone around a hospital has more time for my patient than I do. Any nurse, orderly, or volunteer can be at his bedside sooner and oftener than I can.

"They" do this for the patient in the hospital, and "they" do that. But "they" are acting on orders. Some such system as mine can help your patient feel what he needs most to feel during his stay in the hospital: the presence of his own personal physician.

END



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Welsh, A. L., and Edo, M.:
L.A.M.A. 122:155, 1955.

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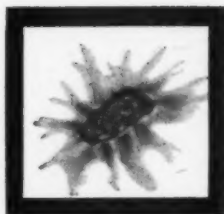
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Formula: each Mucotin tablet contains: natural gastric mucin 160 mg. (2½ gr.), aluminum hydroxide gel 250 mg. (4 gr.), magnesium trisilicate 450 mg. (7 gr.).

Mucotin



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the antacid with natural gastric mucin



How to Spot the Financially Irresponsible Patient



You can do it without checking every new patient's credit rating. Here are some clues from medical collectors

By Robert L. Brenner

More than a year ago, a wealthy and influential store-owner walked into the office of a young Pennsylvania radiologist. The new patient said he'd been referred for hip X-rays. After that visit came three more. At the end of the month, the radiologist sent the man a bill for \$40 for services rendered.

Since then, twelve more

monthly statements have been sent out—all in vain. The well-to-do patient has never paid. And by now the radiologist is convinced he never will pay.

"Losing the \$40 isn't what bothers me most," this doctor recently told MEDICAL ECONOMICS. "It's wondering how I could have spotted such a man as a poor credit risk."

The doctor's question has led this magazine to take a new look at methods that can help doctors spot the potential deadbeat. The problem has been put to several well-established medical collection agencies in various parts of the country. Their consensus:

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(HYDROCHLOROTHIAZIDE)

simplifies* and
improves any
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Initiate therapy with HYDRODIURIL: one 25 mg. tablet or one 50 mg. tablet once or twice a day. HYDRODIURIL by itself often causes an adequate drop in blood pressure over a period of two to three weeks. This may be all the therapy some patients require.

Add or adjust other agents as required: HYDRODIURIL enhances the activity of all commonly-used antihypertensive agents; thus, the dosage of other medication (rauwolfia, reserpine, hydralazine, veratrum) should be initiated or adjusted as indicated by patient condition. If a ganglion-blocking agent is contemplated or being used, usual dosage must be reduced by 50 per cent.

Adjust dosage of all medication: the patient must be frequently observed and careful adjustment of all agents should be made to establish optimal maintenance dosage.

Supplied: 25 mg. and 50 mg. scored tablets HYDRODIURIL (Hydrochlorothiazide) bottles of 100 and 1,000.

Additional literature for the physician is available on request.

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MEDICAL ECONOMICS - SEPTEMBER 28, 1959 151

THE FINANCIALLY IRRESPONSIBLE PATIENT

You can't spot *all* financially irresponsible patients in advance. But you can spot *many* of them.

First, a word on what's meant by financially irresponsible. It doesn't mean the patient who can't afford to pay. Few physicians begrudge giving such people a break. But they do begrudge giving their services free to people who are able to pay but don't.

Such deadbeats are everywhere, but they're still a small minority. Most collectors say

that not more than 2 or 3 per cent of all patients are in this category. So it wouldn't pay most doctors to check every new patient's credit rating in order to spot the very few who may turn out to be deadbeats. Nor would it pay to pry too far into each new patient's financial status yourself. You'd risk offending too many perfectly reliable credit risks.

What credit men recommend instead is that doctors make the best use of two tried-and-true



"Come now, Beasley. I know Miss Brown is attractive, but three hours doing her urinalysis . . ."

FOR UNMATCHED TOLERANCE AND OPTIMAL ABSORPTION MOL-IRON[®] WITH VITAMIN C

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MOL-IRON
WELL TOLERATED

97.9%

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Each contains—Mol-Iron (ferrous sulfate 195 mg., and molybdenum oxide 3 mg.) plus ascorbic acid 75 mg. Bottles of 100. Dose—1 or 2 tablets t.i.d.

1. Brit. M. J. 1:407, 1952. 2. Bull. Margaret Hague Mat. Hosp. 1:68, 1949. 3. Am. J. Obst. & Gyn. 57:341, 1949. 4. Connecticut M.J. 14:230, 1950. 5. J. Lancet 66:218, 1949. 6. Am. J. Obst. & Gyn. 62:947, 1951. 7. Am. J. Med. Sc. 212:76, 1946. 8. Obst. & Gynec. 5:201, 1955. 9. J. Ped. 41:170, 1952. 10. Ann. Int. Med. 42:450, 1953.

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Gouty Arthritis: "...95 per cent of patients experienced a satisfactory response..."¹

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with 21.8 per cent showing minor improvement..."² **Osteoarthritis:** 301 cases showed "...a total of 44.5 per cent with complete remission or major improvement. Of the remainder, 28.2 per cent showed minor improvement..."³ **Spondylitis:** All patients "...experienced initial major improvement that was maintained throughout the period of medication."⁴ **Painful Shoulder Syndrome:** Response of 70 patients with various forms showed "...8.6 per cent complete remissions, 47.1 per cent major improvement, 20.0 per cent minor improvement..."⁵

References: 1. Graham, W.: *Canad. M. A. J.* 79:634 (Oct. 15) 1958. 2. Robins, H. M.; Lockie, L. M.; Norcross, B.; Latona, S., and Riorden, D. J.: *Am. Pract. Digest Treat.* 8:1758, 1957. 3. Kuzell, W. C.; Schelfarzik, R. W.; Naugler, W. E., and Champlin, B. M.: *New England J. Med.* 256:368, 1957.

Availability BUTAZOLIDIN[®] (phenylbutazone ester): Red coated tablets of 100 mg. BUTAZOLIDIN[®] Alka: Capsules containing BUTAZOLIDIN[®] (phenylbutazone ester), 100 mg.; dried aluminum hydroxide gel, 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide, 1.25 mg.

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procedures. First, get a line on the new patient from the form that your aide has the patient fill out for the record folder. Second, learn more about the patient by chatting with him after consultation—and be guided accordingly.

Both these points of contact with the new patient, credit men say, can often alert you to the patient who's likely to renege on his doctor bills. The clues to keep in mind are these:

1. The no-pay patient often hasn't been at his present address or his present job very long.

This doesn't mean, of course, that anyone who has recently changed addresses or jobs is a potential deadbeat. But he's likely to be a poorer risk than someone who has stayed put, credit men say. One collector estimates that 85 per cent of doctors' uncollected debts today is owed by patients who've moved away since getting treatment. If your new patient hasn't been in town or at his current job very long, that may be a tip-off that he'll move again soon.

2. The no-pay patient will often try to impress you with his ability to pay.

Look out for the patient who says, "Don't worry about the cost, Doctor. Do whatever's necessary for my health." He's the most likely of all to be difficult or impossible to collect from. As one credit bureau manager puts it:

"It's just not normal for a person not to care how big a bill he runs up. The average patient, regardless of his economic or social status, wants an idea of what his treatment is going to cost. Chances are the patient who says he doesn't care is either trying to live way beyond his means, or simply has no intention of paying."

So much for the two most common clues to the potential no-pay patient. Not only can you spot the new-in-town and the cost-is-no-object patients. You can also keep many of them from becoming collection problems.

How? Simply by making sure you get answers to two or three pertinent questions from each new patient. These questions can be included in the personal-history form your aide has new patients fill out (the system most credit men recommend). Or you can ask them of the patient yourself (the method many doctors

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IRRESPONSIBLE PATIENT

prefer). Then you must follow through in your talk with the patient before he leaves the office.

The talk gives you your chance to be candid about payment—if the way you've sized up the new patient prompts that kind of candor. But first, what kind of personal-history form do you need? Well, credit men say that if the one you're now using asks only where the patient lives and where he works, it's not much help in spotting a potential deadbeat.

What You Need to Know

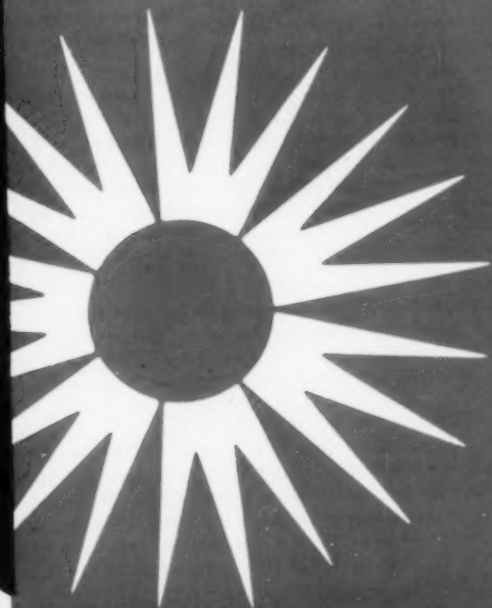
"You should find out how long the patient has been in his present job and at his present address," says a California credit man. "It's also a sound idea to learn who referred the patient to you. If he came from another doctor or a prompt-paying patient, chances are he's a good risk. Good patients usually refer good new patients, and poor payers usually send people like themselves."

It may seem hard to put such questions discreetly, without irritating some patients. That's why many credit men recommend that the doctor avoid asking the questions directly. There's apparently less risk of offending if queries about em-

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a new drug for depression

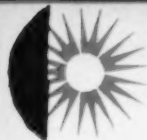
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the mood brightener



Although depression has been notoriously resistant to therapy, successful treatment is now possible with NIAMID, Pfizer's new, full-range antidepressant.

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NIAMID

the mood brightener

MORE EFFECTIVE

Unlike many previous antidepressants, NIAMID is clinically effective in a broad range of the more severe depressive states.

In addition, a wide variety of the milder depressive syndromes, including masked depression, so frequently seen in general practice respond effectively to NIAMID. These include: depression associated with the menopause, postoperative depressive state, and senile depression; depression accompanying chronic or incurable illness, such as gastrointestinal and cardiovascular disorders, and inoperable cancer.

While tranquilizers have had some measure of effect on the anxiety component of depression, NIAMID now gives the general practitioner and the specialist an effective, well tolerated drug which can be used with confidence in the treatment of a full range of depressive states.

DOSAGE: Start with 75 mg. daily in single or divided doses. After a week or more, adjust the dosage, depending upon patient reaction, in steps of one or one-half 25 mg. tablet. Once improvement is seen, gradually reduce dosage to a maintenance level. Many patients respond to NIAMID within a few days, others in 7 to 14 days. A few patients may require as much as 200 mg. daily over a longer period of time before results are noted.

PRECAUTIONS: Side effects are most often minor and mild, and usually may be modified by a reduction in dosage. Hypotensive effects have rarely been noted, and no jaundice or other evidence of liver damage has been reported in patients receiving NIAMID. However, the possibility of hepatic reactions should be kept in mind, particularly in patients with a history of liver disease.

SUPPLY: NIAMID is available as 25 mg. (pink) and 100 mg. (orange) scored tablets.

Already clinically proved in several thousand patients—

Complete references and a Professional Information Booklet giving detailed information on NIAMID are available on request.

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THE FINANCIALLY IRRESPONSIBLE PATIENT

ployment, length of residence, etc., simply appear on a form that your aide asks the patient to fill out.

Use Your Own Judgment

How should you use this information once you get it? With discretion. "Don't make the mistake of letting it dictate your credit policy," a Chicago collector warns. "If you do, you may withhold credit from plenty of patients who are perfectly good risks.

"The patient's personal history can serve you only as a rough

guide. It's useless unless you're willing to discuss fees frankly with any new patient you're not sure about."

Here's how this man suggests handling such discussions:

"If one office visit is all the new patient requires, simply tell him at the end of that visit what the fee is. Most people will offer to pay then and there. Even if they don't, your mentioning the matter tells them you intend to hold them to their obligation. This alone will keep many potential deadbeats from ignoring your bill. *More▶*



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yes, any rheumatic "itis" calls for
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in eight cases of acute
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mg.), phenacetin (120 mg.),
caffeine (30 mg.), salicylamide
(150 mg.), chlorothes citrate
(25 mg.). Also as SYRUP
(lemon-lime flavored),
caffeine-free.

1. Based on estimate by Van
Volkenburgh, V. A., and
Frost, W. H.: *Am. J. Hygiene*
71:122 (Jan.) 1933.



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Pearl River, New York

it
started
as a
"cold"...

THE FINANCIALLY IRRESPONSIBLE PATIENT

"Above all, don't be too concerned about collecting for the first office visit," he continues. "The \$4 or \$5 loss isn't too important. It's when the new patient needs repeated or higher-cost services that you should satisfy yourself that he's financially responsible."

Arrange a Payment Plan

"If the patient is going to need several treatments, you'll naturally tell him so. This gives you an opening to give him some idea what the total cost will be. Then, if you're doubtful about his willingness or ability to pay, ask whether he thinks he'll have trouble paying that amount. If he says yes, that's your cue to work out a reasonable payment plan you feel he can stick to."

When to Check Up

But beware of the patient who says airily: "Trouble paying? Of course not!"

"That," says the Chicago collector, "is your cue to check the patient's local credit rating. Maybe he *is* perfectly able to pay. But chances are just as good that he's got bills outstanding all over town. Unless you want to drop to the bottom of a long list of

creditors, now is the time to find out about him."

That's all there is to the system. You can use it without antagonizing new patients who are good credit risks. Yet it'll help you spot many of those who are financially unreliable—and help you keep them from becoming collection problems. Credit men admit, though, that it won't screen out *all* your no-pays.

Don't Bite Again

It won't work, for instance, with people like the Pennsylvania merchant who simply doesn't choose to pay his radiologist. About all a doctor can do with patients like that, credit men agree, is not get stuck by them twice. Here's the radiologist's latest report on that situation:

"The man came back to me for more work just a few weeks ago," he says. "I didn't refuse to see him because of his unpaid \$40 bill. But I did tell him that since it was still outstanding, I'd have to ask for cash this time."

"He paid without a murmur—but only for this latest visit. He still hasn't paid the \$40. And I guess he never will." END



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MEDICAL ECONOMICS · SEPTEMBER 28, 1959 163

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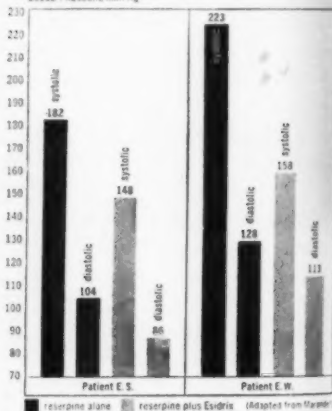
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*Esidrix is at least 10 times more active than chlorothiazide and greatly increases sodium and chloride excretion; however, it has no more effect on potassium excretion than does chlorothiazide.

Esidrix-Serpasil gives excellent results in hypertensive patient with tachycardia; slows heart rate and lowers blood pressure to within normal limits two weeks after therapy.



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Esidrix-Serpasil lowers blood pressure more effectively: Blood pressure response is better with Esidrix-Serpasil combination tablets than with Serpasil alone—and more rapid, too.

Esidrix-Serpasil controls complicating symptoms: With its calming action, the Serpasil component relieves anxiety that often accompanies hypertension. Serpasil also slows heart rate when tachycardia is present, while Esidrix promotes diuresis in edematous patients.

Esidrix-Serpasil reduces side effects: The potentiating effect of Esidrix on Serpasil lowers dosage requirements, hence with Esidrix-Serpasil the incidence and severity of side effects are appreciably reduced.

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SUPPLIED: Esidrix-Serpasil Combination Tablets, each containing 25 mg. of Esidrix and 0.1 mg. of Serpasil; bottles of 100.

REFERENCE: I. Maronde, R. F.: Clinical report to CIBA. ESIDRIXTM (hydrochlorothiazide CIBA) SERPASIL[®] (reserpine CIBA)

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(hydrochlorothiazide and reserpine CIBA)

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comprehensive relief of severe cold complaints

formula

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salicylamide	0.19 Gm
phenacetin	0.13 Gm
caffeine	30 mg
ascorbic acid	0.05 Gm
methamphetamine hydrochloride	1.25 mg

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SENATOR HUMPHREY PRESCRIBES:

'The Way to Keep Medicine Free'

A pharmacist by profession, this liberal Presidential candidate thinks doctors can hold medical costs down without Government intervention. But as for hospital costs . . .

Minnesota's favorite son says the country needs "a walking, talking liberal" in the White House. And his friends ask, "Who but Hubert?" Senator Hubert H. Humphrey is known as a man of strong opinions and many words.

But in a recent talk with MEDICAL ECONOMICS' Lois R. Chevalier, the Senator didn't sound

like the standard liberal politician. He showed surprising awareness of what doctors are doing to hold medical costs down. He indicated a willingness to let them get on with the job without Government interference. At the same time, he pointed to a health-cost problem that's largely beyond doctors' control. In the following tape-recorded interview, he explains why he's a "health man" with a mission:

Q. Senator, can you tell me how your mail is running on health matters?

A. Most of it is about older people and their health-cost problems. I've introduced a bill

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J. Ausman, D. C.: J. Am.
Geriatric Soc. 7:268, 1959.

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'TO KEEP MEDICINE FREE'

to provide sixty days of hospitalization and sixty days of nursing home care for Social Security beneficiaries. It's not the same as the Forand bill; it does *not* provide Government payment for doctors' services.

Q. Don't you favor Government payments to doctors?

A. I see no reason to get into a conflict with the medical profession. You see, I know something about how doctors feel. I'm a pharmacist. I still fill prescriptions when I'm at home. And I'm keenly interested in medical matters.

Q. In other words, you're something of an insider, not an outsider?

A. I go to pharmaceutical meetings, and I visit hospitals and research laboratories. I try to keep up with the new drugs, though I must say it's difficult these days.

Oldsters' Chief Problem

Q. Do you think that if we simply provide hospitalization and nursing home care for the aged, we'll be solving their major health-cost problem?

A. Yes. What bears down on the aged the hardest is the cost of prolonged hospitalization.

Q. Are you assuming, then, that doctors can be counted on

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'TO KEEP MEDICINE FREE'

to keep their fees low for retired people of limited means?

A. Yes, I hope so. I'm convinced that the medical profession, by its own self-discipline, can do much to relieve the burden of costs. And such self-discipline is the best argument against Government intervention.

Q. Do you mean that you expect doctors actually to police their own fees for the aged?

A. I think they do, in most instances. They do in my state. I've looked into the medical and surgical costs in some of our hospitals. And I'm sure that doctors in general are trying to be modest in their charges to elderly retired people. I suggest that local medical societies establish committees to exercise voluntary control over medical fees for the elderly.

Q. What about the additional load that the program you're sponsoring would put on the hospitals?

Doctors to Control Use

A. I'd be less than honest if I didn't admit that this is something we'll have to face up to. In the beginning, there may be overutilization. But I doubt that it will continue. I have the feeling that most people don't like hospitals well enough to want to make them their homes. I also

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'THE WAY TO KEEP MEDICINE FREE'

feel that certain standards could be applied in order to restrict the few joy-riders. After all, people can go to hospitals only on doctors' orders.

Q. Then you'd rely on physicians to keep down abuses?

A. That's right. I'd expect the medical profession to set high standards of professional conduct.

Q. Do you believe that doctors *have* kept down abuses in Medicare and the disability program under Social Security?

A. Certainly the disability program hasn't been overused. It's been very conservatively administered. If anything, a reverse criticism might apply. We may have been a little too tight-fisted.

Of course, you can always find somebody who'll cheat. But as I see the fundamental issue, it's this:

The way to keep medicine free of Government domination is to keep the total cost of health care within the means of the people



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"THE WAY TO KEEP

who need it. That's why I feel that if you can trim off the ends, so to speak—if you handle hospitalization of the aged separately—you can preserve the vast amount of medical care on a strictly private basis.

But if you load the voluntary insurance plans with all the aged and the chronically ill, rates are bound to skyrocket. If that happens, people are likely to turn to the Government for the whole health job.

Q. As things are shaping up, do you think we'll still have free-enterprise medicine in this country ten years from now?

Groups Are a Compromise

A. I'm convinced that group medical practice is beginning to take a greater hold. It's halfway between public medicine and the traditional doctor-patient relationship. In support of this trend, I've also introduced a bill to provide low-interest, long-term Government loans for building health-service facilities.

At first, the bill was severely criticized because it stipulated that such facilities must be group health cooperatives, with governing boards on which laymen were in the majority. But we've revised the bill so that it can't be criticized as special legislation

MEDICINE FREE?

for a special segment of the population.

As we visualize it, the loans would be available to any non-profit association, whether organized by a group of private doctors or other citizens, offering a prepaid health-service plan. Thus we'd be helping to start groups that would be able to efficiently serve a large number of people.

The 'Doctor Shortage'

Q. Senator, you've used the word "efficiently." Tell me, do you think we have enough doctors to provide efficient care for the American people? Or do you feel that there's a shortage of doctors?

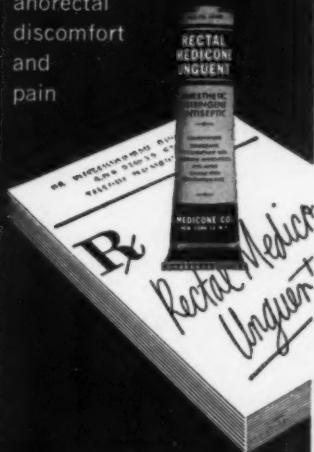
A. I feel there's a shortage. But I don't have facts to back up my feeling. What we need is a continuous objective study on the availability of adequately trained doctors to protect America's health. It's not only the number of doctors that's important but also their quality and training.

I believe that a few good doctors with a modern clinic can do more than a dozen medical men in their own individual offices. Considering the trend toward groups, we may have to re-evaluate what we call the shortage of

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FOREMOST IN THE FIELD OF ANESTHETIC
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'THE WAY TO KEEP MEDICINE FREE'

doctors. It may not be so great as some of us lay people think.

Q. But does anyone know the market potential for health services? We probably know more about how to save lives and prevent suffering than we have money to pay for. How much can our economy afford to devote to health?

'An Expanding Market'

A. A good deal more than we're currently paying. I don't think there's any doubt about that.

But you don't have to achieve

better health through compulsion. There's an expanding market for health care; and people can be educated to the idea that more care is going to cost them more money. With a proper program of education in a progressive, prosperous economy, the public will learn to demand more intensive medical care for serious conditions, as well as better preventive medicine.

We've barely begun to tap the market. And I'm certain we can go a long way forward without encroaching on the rights of private practitioners. **END**

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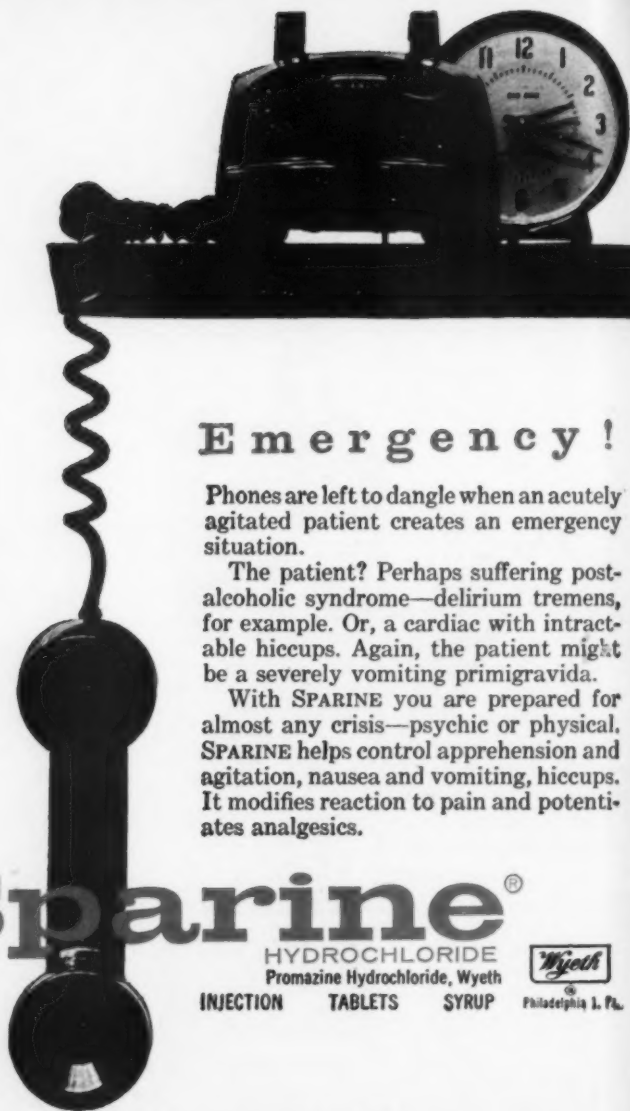
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What Doctors Do When Patients

Miss Appointments

A few physicians charge a fee for the wasted time. But most feel there are better ways to handle the problem. For instance . . .

By Hugh C. Sherwood

Do you ever charge patients who break appointments without notifying you in advance? A California G.P., Dr. George R. Farrell, does. He charges his usual office visit fee to second offenders. And he says his system has trained his patients to honor the appointment schedule. (For full details, see "How I Keep Patients From Missing Appointments," MEDICAL ECONOMICS, March 30, 1959.)

Do doctors in general like Dr. Farrell's idea? Or do many of

them feel they have better ways of coping with the problem? To find out, MEDICAL ECONOMICS has asked several dozen of its readers what they do about missed appointments. The responses indicate that many American physicians see no need for a system as drastic as Dr. Farrell's.

A few of the queried men are in his camp, to be sure. ("I charge for any appointment that's broken without notification," says a veteran G.P. in Yorktown, Va. "After all, the

WHEN PATIENTS MISS APPOINTMENTS

patient has *some* obligation.") Most of these physicians feel that half of a routine office visit fee is more appropriate than the full charge, however.

An occasional doctor evidently wishes he *could* bring himself to charge for a "lost" hour. "I believe Dr. Farrell's method is a good one for G.P.s and would work for most specialists," says a St. Louis radiologist. "But as for me, I don't make the patient pay up."

Why They Don't Charge

Very few of the doctors do "make the patient pay up." A great many believe it's wrong to do so. Here are the four main reasons why most of the surveyed men don't charge:

1. *They don't find missed appointments a problem*—either because they don't use an appointment system or because few of their patients seem to break appointments without notification. Says a G.P. in Mayodan, N.C.: "I see no urgent reason to charge the very few patients who fail to show up."

2. *A missed appointment often means a welcome break in the schedule.* So the doctor isn't disposed to penalize patients

who make such breaks possible. As a G.P. in North College Hill, Ohio, puts it: "Personally, I enjoy a missed appointment now and then. It gives me a chance to catch a smoke, stretch my legs, and get a little routine paper work done."

'A Discredit to M.D.s'

3. *It's bad public relations to charge for missed appointments,* as some men see it. A surgeon in Sacramento, Calif., declares: "Why don't I charge? Because charging for missed appointments is a discredit to the medical profession. Why make our public relations problem more difficult than it is?"

They'd Resent It

4. *The disciplined patients are likely to rebel.* Explains an internist in Rapid City, S.D.: "Dr. Farrell's suggestion is an interesting one, but I suspect it wouldn't work in my community. Many of my patients are ranchers and resent being sent any statements at all. They tell me they'll pay when they sell their stock in the fall—and they usually do."

But suppose the problem does loom large in your office? Is



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WHEN PATIENTS MISS APPOINTMENTS

there a better way to handle it than by charging the no-show patients? Some of the queried doctors have suggestions of their own. Among them:

¶ When any patient has missed two appointments, a Wilton, Conn., G.P. tells him he'll have to take pot luck next time, or that he may even have to wait until all other patients are treated.

¶ A neuropsychiatrist in New Brunswick, N.J., and an ophthalmologist in West Chester, Pa., threaten to refuse to see patients who miss appointments. Explains the ophthalmologist: "When such a patient calls for another appointment, my aide reminds him he didn't keep the first one. She tells him that if he doesn't keep the second, he won't be able to get another."

¶ Several physicians prefer preventive action: They write or phone to remind patients of im-

pending appointments. Says a San Antonio, Tex., ophthalmologist: "My aide makes a reminder call to everybody who has made an appointment more than a week in advance."

Tighter Schedules

¶ An orthopedist in Far Rockaway, N.Y., and an OB/Gyn. woman in Whittier, Calif., make a point of scheduling enough patients so they won't have time to waste if any individual doesn't show up.

¶ And a Seattle urologist follows a course that's open to any physician, whether or not he does surgery. "I believe this problem can be solved through good doctor-patient relations," he says. "I impress on most patients that follow-up visits are for their own protection. The patient who knows the importance of an appointment is very apt to keep it." END

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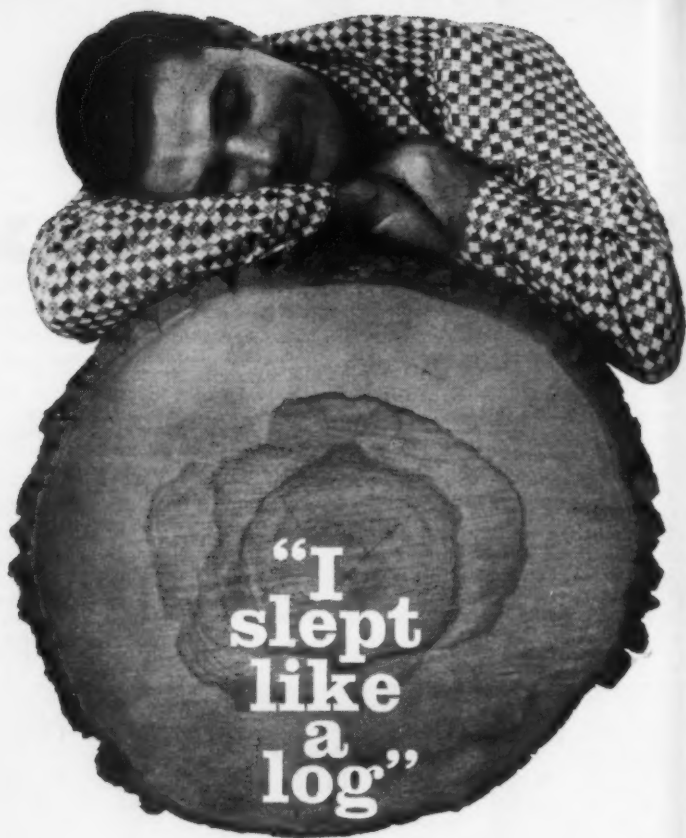
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300 mg CAPSULES

Now a Noludar dosage form for every sedative-hypnotic need

When sleeplessness
is a real problem

NOLUDAR 300 mg

1 capsule at bedtime

For gentle
hypnotic effect

NOLUDAR 200 mg

1 tablet at bedtime

For daytime
sedation

NOLUDAR 50 mg

50 to 100 mg
three or four times daily

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MEDICAL ECONOMICS • SEPTEMBER 28, 1959 187

The \$150,000 Blood Transfusion

Continued from 95

sure the patient or his relatives are promptly and fully informed of any complications that have developed. Prompt disclosure of mistakes promotes good-will and understanding, even though compensation must be made for the mistake."

Dr. Pulrang tends to endorse this view. Because of their confidence in him, the deceased woman's family were reluctant to sue, he recalls:

"I did explain at once to the family what had happened. And for a whole month, they refused to sign the necessary legal papers to start the suit. Up to the end they wanted to keep my name out of it."

Dr. Pulrang also feels strongly that he was found liable only as "the captain of the ship." He says it was the only point Mr. Berman made against him.

But let's suppose that, like Dr. Pulrang, you don't succeed in heading off a suit. Should you seek a settlement out of court? Lawyers second-guessing the

jury's \$150,000 verdict in the Yonkers case believe an effort to settle should have been made before the case went to trial.

That's a good second guess. A mistake had been made in the operating room. The patient had died. And as the mother of two young children, she naturally had the jury's sympathy. Everybody concerned agreed on those facts before the trial started. Why, then, didn't the defendants try for a settlement?

The answer is illuminating:

The three defendants either couldn't or wouldn't follow a single line of action. Each was covered by a different insurance company. There were three different sets of defense counsel. All agreed there'd been a mistake. But none would agree on whose mistake it was. Their failure to stand together undoubtedly weakened their position.

During the trial, for example, each of the defense counsel appeared to be busy trying to prove one of the *other* defendants at fault. Comments one informed observer: "No plaintiff's attorney ever had an easier time. And Emile Zola Berman is one trial lawyer who needs little help in a courtroom." **More►**

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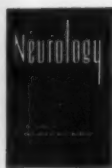
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QUESTION:

What have authorities reported as to the efficacy of Fiorinal in tension headache?

ANSWERS:

From the published reports of leading clinicians.



"The most effective symptomatic medication in the treatment of tension headache have been several analgesic and sedative combinations. One of the most effective is

Fiorinal, which yielded relief in two out of three patients." (Friedman, A. P., von Storch, T. J. C. and Merritt, H. H.: *Neurology* 4:773, Oct. 1954.)

"In the treatment of tension headaches ... [Fiorinal's non-narcotic action] offers a better opportunity for relief than some usually prescribed non-narcotic analgesics." (Weisman, S. J.: *Am. Pract. & Digest. Treat.* 6:1019, July 1955.)



"Fiorinal appears to be one of the most useful preparations to date for the relief of tension headaches. Easing of the head discomfort was accomplished by one or

two tablets without any unpleasant side effects such as drowsiness or gastric upsets. In many cases Fiorinal appeared to temporarily relieve the discomfort from sinus trouble or acute respiratory infections." (Kibbe, M. H.: *Dis. Nerv. System* 16:77, March 1955.)

specific therapy
for
tension
headache



Fiorinal®

relieves pain, muscle spasm, nervous tension
rapid action • non-narcotic • economical

FIORINAL TABLETS

Each tablet contains:
Sandoptal (Allylbarbituric acid N.F.X) 50 mg. ($\frac{1}{2}$ gr.),
caffeine 40 mg. ($\frac{2}{3}$ gr.),
acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 tablets every 4 hours according to need, up to 6 per day.



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plus other
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of other anti-
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...is effective by itself in a majority of patients with mild or moderate
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- more hypertensives can be better controlled with DIUPRES alone than with any other agent . . . with greater simplicity and convenience, and with decreased side effects
- can be used as total therapy or primary therapy, adding other drugs if necessary
- in patients now treated with other drugs, can be used as replacement or adjunctive therapy
- should other drugs need to be added, they can be given in much lower than usual dosage so that their side effects are often strikingly reduced
- organic changes of hypertension may be arrested and reversed . . . even anginal pain may be eliminated
- patient takes one tablet rather than two . . . dosage schedule is easy to follow
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DIUPRES-500 500 mg. DIURIL (chlorothiazide),
0.125 mg. reserpine.

One tablet one to three times a day.

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0.125 mg. reserpine.

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THE \$150,000 BLOOD TRANSFUSION

Here's a sample from the court record:

DENNIS L. O'CONNOR, counsel for the hospital: The hospital did not provide any blood for [the patient]. There was no order for it. Indeed, they didn't prepare any of it. They didn't have her signature. They had no blood of any kind for [the patient] . . . Before Dr. Pulrang is on the stand more than two minutes, he will admit he didn't order blood.

J. J. BROPHY, counsel for Dr. Pulrang (interposing): If Your Honor pleases, I already said that in the presence of the jury. Why harp on it? It is repetitious.

MR. O'CONNOR: I don't know about that.

MR. BROPHY: May my brother counsel be confined to an opening statement?

MR. O'CONNOR: We expect to prove these things.

THE COURT: Go ahead.

MR. BROPHY: I respectfully ask an exception.

At another point during the trial, Dr. Pulrang was cross-examined by one of the defense counsel (other than his own) as follows:

Q. Doctor, did you examine this blood to make sure it was the right type before it was administered?

A. No.

Q. Why?

A. I was busy operating, and it is not part of the procedure. That is the job of the anesthetist administering the transfusion.

Q. Doctor, couldn't you have just stepped over and looked over his shoulder?

A. No, that would be breaking the surgical technique and just isn't done.

Q. Doctor, you testified that you had three M.D.-assistants. Couldn't you have delegated one of them to check this blood?

A. No, they were all within the sterile field, and it would be contrary to all surgical techniques. In some twenty-nine years of operating in this hospital, I have never done such a thing. In fact, I would not have dreamed of delegating one of my assistants to check the blood.

Q. (to the jury): The doctor would not have dreamed of delegating one of his assistants to check this blood,

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age . . .
and growing
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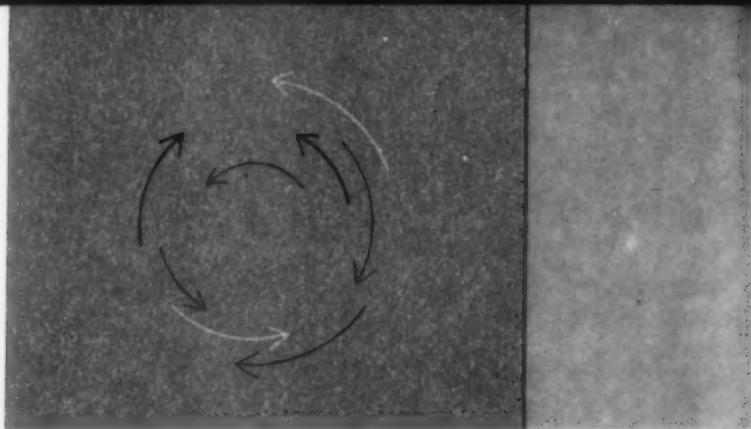
FORMULA: Each fluidounce contains:

Iron peptonized	420 mg.
(Equiv. in elemental iron to 71 mg.)	
Manganese citrate, soluble	158 mg.
Thiamine hydrochloride	10 mg.
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Vitamin B ₁₂ Activity	20 mcg.
(Derived from Cobalamin conc.)	
Nicotinamide	50 mg.
Pyridoxine hydrochloride	1 mg.
Pantothenic acid	5 mg.
Liver fraction 1	2 Gm.
Rice bran extract	1 Gm.
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*Keith, J.H.: Utilization and Toxicity of Peptonized Iron and Ferrous Sulfate, *Am. J. Clin. Nutrition* 1:35 (Jan.-Feb., 1957).

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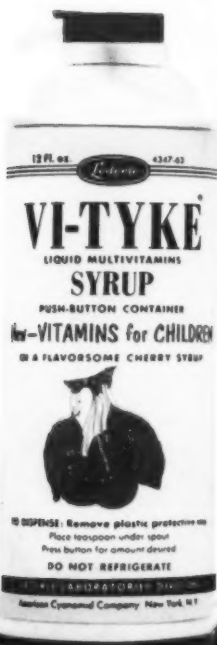
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SYRUP: Each 5 cc. (tsp.) daily dose contains:

Vitamin A (Palmitate)	3,000 U.S.P. Units
Vitamin D	800 U.S.P. Units
Thiamine HCl (B ₁)	1.5 mg.
Riboflavin (B ₂)	1.5 mg.
Pyridoxine HCl (B ₆)	1 mg.
Ascorbic Acid (C)	50 mg.
Vitamin B ₁₂	3 mcgm.
Niacinamide	10 mg.
Pantothenic Acid (as Panthenol)	1 mg.
Methylparaben	0.08%
Propylparaben	0.02%

DROPS: 0.6 cc. daily dose contains:

5,000 U.S.P. Units
1,000 U.S.P. Units
1 mg.
0.8 mg.
1 mg.
50 mg.
1 mcgm.
10 mg.
2 mg.
0.08%
0.02%

CAPACITY
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300

200

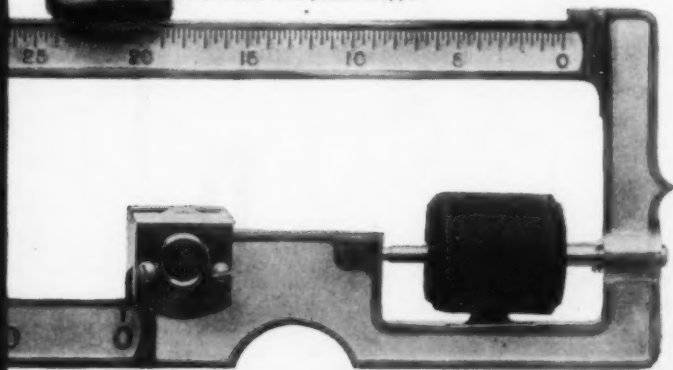
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a new member of the Lederle
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60 cc. bottle with plastic dropper



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THE \$150,000 BLOOD TRANSFUSION

even to save this woman's life! Objections were immediately raised by the plaintiff's attorney, Mr. Berman, and by Dr. Pulrang's own counsel. And this damaging comment was stricken from the record. But it points up sharply the division among the defense counsel.

In this same vein of disagreement, the defendants couldn't agree on a settlement offer. At

one point during the trial, settlement negotiations were held in the judge's chambers. For a while, settlement appeared possible for a total of \$101,000—\$42,000 apiece from the insurance companies covering the hospital and Dr. Rubin, and \$17,000 from Dr. Pulrang's carrier under a group policy written for the American College of Surgeons. But the deal fell through





"It's some life insurance company. They want to know if you'll examine patients at home Sunday evenings and holidays. They'll pay \$5."

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Each TR
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Dosage: 6
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Monthly 37
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running noses  
and open stuffed noses orally

Triaminic®

the leading oral nasal decongestant

- in nasal and paranasal congestion
- in sinusitis
- in postnasal drip
- in allergic reactions of the upper respiratory tract

safer and more effective than topical medication^{1,2,3}

- systemic transport to all respiratory membranes
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- avoids "nose drop addiction"

Relief with Triaminic is prompt and prolonged because of this special timed-release action... beneficial effect starts in minutes, lasts for hours



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 more hours of relief

Each TRIAMINIC Tablet provides:

Phenylpropanolamine HCl50 mg.
Pheniramine maleate25 mg.
Pyriminamine maleate25 mg.

One-half of this formula is in the outer layer, the other half is in the core.

Dosage: One tablet in the morning, mid-afternoon and at bedtime.

References: 1. Lhotka, F. M.: Illinois M. J. 112: 250 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958.

TRIAMINIC JUVELETS: Each timed-release Juvelet is equivalent in formula and dosage to one-half of a TRIAMINIC tablet, for the adult or child who requires only half strength dosage.

TRIAMINIC SYRUP is recommended for adults and children who prefer liquid medication. Each 5 ml. tsp. is equivalent to 1/4 of a Triaminic Tablet. *Adults:* 2 tsp. 3-4 times a day; *children 6-12:* 1 tsp. 3-4 times a day; *children under 6:* in proportion.

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THE \$150,000 BLOOD TRANSFUSION

when the three companies could not agree on how much each should put up.

Instead, the case went to a jury. The jury's verdict of \$150,000 was later reduced by Justice Doscher to \$135,000. But even the smaller figure works out to \$45,000 for each of the defendants. According to several lawyers with whom I've discussed the Yonkers verdict (which, by the way, has been appealed), an *early* settlement might have been far less severe.

What lessons are to be drawn from the Yonkers story? I think a number of conclusions are justified:

1. Blood is potential dynamite. As Dr. Jacob Geiger says, the doctor who orders a transfusion is assuming a big legal risk.

2. The doctor who does as-

sume such a risk should be sure he can prove that everything he has done was medically indicated.

3. If something goes wrong, the doctor's best procedure is to explain the complications fully and promptly to the patient or his relatives. Even if such frankness doesn't head off a malpractice action, it may facilitate out-of-court settlement.

4. If a lawsuit is begun, the possibility of settling out of court is usually worth careful consideration. It may save the doctor time, money, and unwelcome publicity.

5. When an accident happens, every doctor involved may face suit along with the hospital. There's little to be gained and much to be lost by bickering about who was directly responsible for the tragedy.

END

he pretender

A Texas wife has sued for annulment of her marriage on the grounds that her husband, while pretending to earn a comfortable living, was actually impoverished. "He pretended to be a bricklayer," she charged, "when actually he was only a hospital resident!"

—SHIRLEY JO BENNETT

FROM THE A.M.A.

“Iron sulfate and other iron salts, which have produced injury, may ultimately be replaced by safer iron compounds...”

A.M.A. Committee on Toxicology:
J.A.M.A. 170:676, June 6, 1959.

FROM FLINT

A chelated iron providing effective, well-tolerated oral therapy that is safer¹

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Chelated iron (FERROLIP) is remarkably soluble; nonionized; not precipitated by pH up to 10.2; stable in presence of alkali, protein, phosphate, phytate. Liquid form does not stain or damage teeth and mixes freely with milk, formula, and fruit juices.

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Also available: During pregnancy—FERROLIP ob Tablets

For macrocytic and microcytic anemias—FERROLIP plus (Capsules and Liquid)

Flint, EATON & COMPANY
Decatur, Illinois

1. Franklin, M., et al.: Chelate Iron Therapy, J.A.M.A. 166:1685, Apr. 5, 1958.

*U.S. Pat. 2,575,611

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Why Some People No Longer Love Doctors

Continued from 87

Sure, I'd heard complaints about icy-veined doctors from my friends. I'd also been scornfully aware of the mossback activities of organized medicine. But a professional historian seldom credits the gossip of his friends. And I supposed that the American Medical Association

reflected the attitudes only of the die-hard mentally indigent: the aged and infirm among this nation's 200,000-odd practitioners of medicine.

Now I know—or at least suspect—that I was being too generous to doctors. It seems that my young internist *was* the modern medical man. His attitudes were the attitudes of his calling, as I've since seen them expressed in the news columns and in far too many M.D.-bylined articles in this estimable publication.

Robert Barton (which isn't his name) practices in the great

the housewife with a head cold
often must "keep on the go"...



Analgesic therapy for this or any patient with a cold can be doubly effective when you prescribe 'Daprisal'. This combination of two analgesics *plus* the mood-lifting components of Dexamyl® (brand of dextro amphetamine and amobarbital) relieves pain and stiffness and, at the same time, overcomes the sluggish, dragging, depressed feeling that increases a head cold's misery. Thus, 'Daprisal' is ideal supportive therapy for your head-cold patient who must "keep on the go."

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easiest way to stop a cough



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Tessalon perles stop cough fast — and they're convenient to take. No mess, no spillage, no awkward spoons or bottles to carry around. Another advantage: *no taste*. An exact, effective dose is sealed in a tiny gelatin sphere.

Reasons *why* Tessalon stops cough so effectively: it acts where cough begins—in the chest; it acts at the cough reflex center—in the medulla; it acts promptly—within 15 to 20 minutes, the effect lasting up to 8 hours. Tessalon is *not* a narcotic, yet has been reported 2½ times more effective than codeine in suppressing cough.¹

SUPPLIED: Tessalon *Perles*, 100 mg. (yellow); bottles of 100. Tessalon *Pediatric Perles* (for children under 10), 50 mg. (red); bottles of 100. Also available (for use when oral administration of Tessalon is precluded): *Ampule*, 1 ml. (5 mg.); cartons of 5.

1. Shane, R.J., Kryski, T.E., and Copp, S.E.: *Canad. M.A.J.* 77:600 (Sept. 15) 1957.

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because many diseases involve emotional and physical stress...

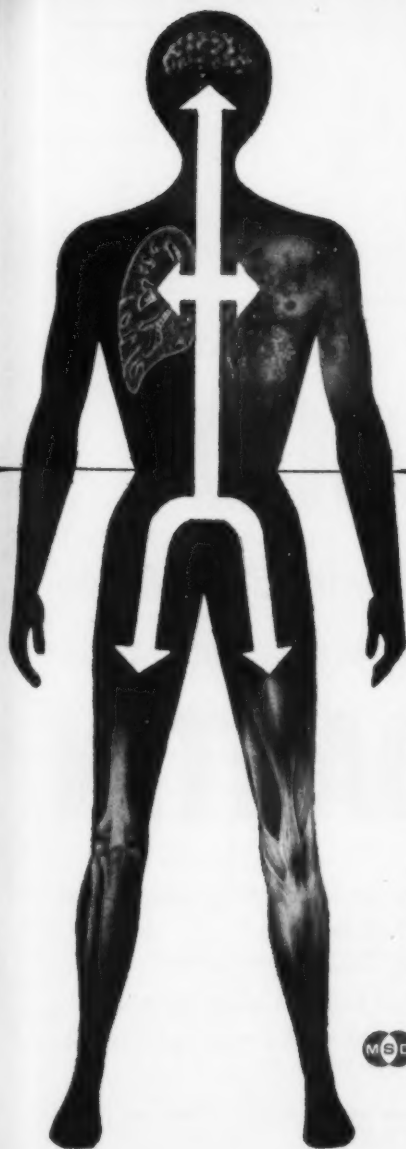
in arthritic and rheumatic
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treats more of
the patient
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DECABAMATE links the action of DECADRON®, the most potent and effective of the anti-inflammatory steroids, with the most widely accepted and well tolerated of the muscle-relaxant tranquilizers, meprobamate . . . By treating more of the patient more effectively, DECABAMATE can make the difference between disability and employability in many rheumatic and arthritic conditions.

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Supplied: As scored yellow tablets providing 0.25 mg. DECADRON plus 200 mg. meprobamate; bottles of 100.

Additional information on DECABAMATE is available to the physician on request.

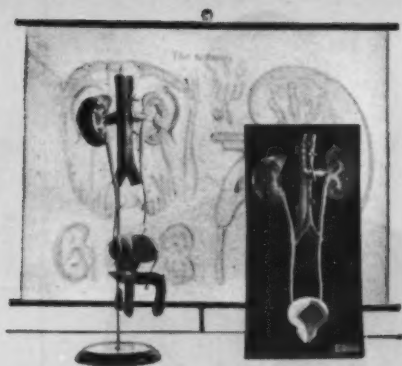
†Rheumatoid arthritis, including palindromic rheumatism, rheumatoid spondylitis, Still's disease, and psoriatic arthritis. Acute, painful inflammatory musculoskeletal conditions (i.e. bursitis, synovitis, and tenosynovitis).

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in genitourinary
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courses of treatment* and still negligible
development of bacterial resistance with

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brand of nitrofurantoin

"... may be unique as a wide-spectrum antimicrobial agent
that ... does not invoke resistant mutants."

Waisbren, B. A., and Crowley, W.: A.M.A. Arch. Int. M. 95:655, 1955.

Available as Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

*Conservative estimate based on the clinical use of FURADANTIN Tablets and Oral Suspension since 1953.

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city of which my college town is a remote suburb. I sought him out for a check-up because, quite simply, I wasn't feeling well. I chose his name from a list of internists furnished me by a local hospital administrator. I noted that he was young, well-educated, and conveniently located. So I phoned his office for an appointment.

Nobody's Patient?

What I had to do, actually, was *plead* for an appointment. The efficient woman at the other end of the wire sounded repelled by my answers to her questions. Was it an emergency? No, not really. Who had referred me? Nobody, really. What was the name of my own doctor? I had none. What, no family doctor? Well, we hadn't needed one in the past few years: My boy was too old for a pediatrician, and my wife and I weren't quite ready for a geriatrician.

'Maybe Next Week'

I could visualize the girl tapping her pointed teeth with a pencil as she made huge calculations. Finally she said: "Doctor could perhaps fit you in next Tuesday at 3."

"Gosh," I said, this being a Wednesday. "Doctor must be a busy man."

"Indeed he is," she answered haughtily. "What is your name, please?"

I gave her my name, beating down the temptation to say that I was a doctor too. But I felt a twinge of envy. "Doctor [without even the definite article] could perhaps fit you in . . ." It had a majestic ring. If only I had such prestige, along with such an awesome lady in waiting . . .

A 40-Minute Wait


I arrived at the office at the appointed hour. There was no one in the outer office except the awesome lady. But Dr. Barton was in; there was no doubt of that. And he was indeed busy, probably with unseen, untold patients. I sat for forty minutes, listening to the comings and goings, whiskings and whirlings, murmurs and mutterings of other voices in other rooms.

For the first twenty minutes, the girl hardly noticed me. Then she looked up, tossed me a practiced smile, and said, "Doctor will only be a moment. While you're waiting, you can fill out this card." More▶



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gastroenteritis
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WHY SOME PEOPLE NO LONGER LOVE DOCTORS

The card was a not very subtle device aimed at sniffing out my credit rating. It made me feel welcome—if I could pay.

When I finally crossed the magic threshold into Robert Barton's reception chamber, I found myself a large desk's width from a most gracious personage. Dr. Barton is soft-spoken and considerate, once you get in to see him. (In later visits, by the way, I never had to wait less than half an hour for the great moment to arrive.) He is also much in demand among his colleagues. The telephone rang four times during our first history-taking session, and each time there fol-

lowed a long doctor-to-doctor confab while I listened in brooding silence.

The doctor apologized to me for each interruption, but in an offhand way that made *me* feel somewhat intrusive. And, although we were nearly of an age, he asked his questions and answered mine—this is what chiefly offended me—in a manner that made our relationship immediately clear:

I was a raw boob, hardly literate and something of a nuisance. He was a lofty seer to whom my ailments were Chapter One of an ancient textbook.

Let me be fair. I stuck with



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CARTOON: AL ROSS
CAPTION: S. BACHMAN, M.D.

"I don't care how much she wanted a boy. It's still not malpractice!"



*"I seem to have the blues all the time...
I can't sleep..."*

in the depressed, unhappy patient
PROMPTLY IMPROVES MOOD
without excitation

- **Acts fast to relieve depression and its common symptoms:** sadness, crying, anorexia, listlessness, irritability, rumination, and insomnia.
- **Restores normal sleep**—without hang-over or depressive aftereffects. Usually eliminates need for sedative-hypnotics.

Composition: Each light-pink, scored tablet contains 1 mg. benactyzine HCl and 400 mg. meprobamate.

Dosage: 1 tablet q.i.d.



for depression

Deprol[†]

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WHY SOME PEOPLE NO LONGER LOVE DOCTORS

Robert Barton to the end. He was a more than competent internist. I feel better physically for having seen him. But he never became *my* doctor. In my mind, he remains a personage rather than a person: a white-jacketed monarch who wields strange machines and instruments in place of a scepter.

His bill, when it came, floored me, though I managed to pay it. Enclosed with the bill was a card. On it was printed some politician's pronouncement on the importance of free choice of physician and of the private, unfettered practice of medicine. I tore it up.

Are You Too Dignified?

By the way, I wonder whether Dr. Barton ever permits people to see him in his shirt sleeves. My brother-in-law doesn't. "Beneath the dignity of the profession," he explains, only half-seriously. But my sister tells me that doctors, like clergymen, have a mortal fear of being caught unbuttoned. In fact, they're so much on guard that the humanity in them seems under wraps, too.

Not just Robert Barton. Not just my brother-in-law. To judge

from notes I've exchanged with my lay friends, the image of the modern doctor in most American minds is now etched in acid.

That's a great pity. It's worse. It's a tragedy for all of us. American physicians evidently believe they can flourish only in a world where stiff collars, stiff necks, and stiff ideas are marks of distinction. But they're tragically wrong.

Patients Aren't With You

Remember this, Doctors: We're living in an age of informality, of flexibility, of swift and startling change. You can battle as much as you like against social developments that seem to threaten your independence. But you can't expect us laymen to rally round your standard—not while you think of us as your property and of yourselves as a beleaguered army of property-holders.

Many a monarch notable for his haughty efficiency has lost a kingdom. Good riddance to any such man. But the healer's kingdom is another matter. I'd hate to see it lost simply because the healer has forgotten his chosen job: to serve, not to be served by, his fellow men.

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New 4 mg. Polaramine Repetabs give your patient daytime or nighttime protection against seasonal and nonseasonal allergens with a single Repetab. Polaramine, the closest to a perfect antihistamine, offers greater therapeutic effectiveness and safety than other antihistamines...at lower dosage...with few, if any, adverse reactions.

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How to Retire On (Not in) a Nursing Home

Continued from 102

regular routine of taking the patient's temperature every four hours, writing nurses' notes, and getting to know the patient thoroughly. On admission, of course, each patient has his blood pressure taken, plus chest X-ray, temperature, weight, and urinalysis. We also study his doctor's record and information from his hospital charts if he has come here from a hospital.

"After the third day, if the patient isn't actually ill, our routine includes weekly nurses' summaries and temperatures twice a week. If any change occurs, the chart is reopened and we go back to the hospital routine until the patient's doctor says he doesn't need such close care."

What Types of Patients?

Most of the patients are long-term cases (a year or more), and quite a few eventually die at the home. They're admitted either on their own or through

a physician. Once admitted, though, each patient must have a doctor. If he doesn't have his own physician (which rarely happens), Dr. Fahrney or Dr. Louis R. Schoolman, a near-by internist, takes over.

Of the twenty-odd hours a week Dr. Fahrney now puts in at Vindobona, only about three are purely administrative. He spends the rest of his time on patient-care. "I say hello to everybody once a week," he explains. "I see all the sick ones every day, and all my own patients two or three times a week."

He Charges Monthly Fees

About 10 per cent of his current income from practice comes from the patients he treats at the home. He charges them by the month—about \$20 a month if they need no special attention, perhaps \$50 if they do.

Such fees are kept separate from the home's charges. Rates for paying patients run from \$75 to \$100 a week in private rooms, \$65 to \$75 in semiprivate, and \$55 in wards. Long-term patients get a reduction of \$5 a week after the first three months.

If extra nursing care is needed, another \$1 or \$3 a day is



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dosage may cause deep sleep in infants and young children.

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relieve the tension—and control its G. I. sequelae ■ ■ ■



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and excessive secretion in G. I. disorders*

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meprobamate (400 mg. or 200 mg.)—a tranquilizer and muscle-relaxant widely accepted for the effective management of tension and anxiety

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200 mg. meprobamate • 25 mg. PATHILON

*for more flexible control of G. I. trauma and tension
smooth, sugar-coated, easy-to-swallow*

PATHIBAMATE-400 and PATHIBAMATE-200 are indicated for duodenal ulcer; gastric ulcer; intestinal colic; spastic and irritable colon; ileitis; esophageal spasm; anxiety neurosis with gastrointestinal symptoms and gastric hypermotility.

Supplied: **PATHIBAMATE-400**—Each tablet (yellow, 1/2-scored) contains meprobamate, 400 mg.; PATHILON tridihexethyl chloride, 25 mg.

PATHIBAMATE-200—Each tablet (yellow, coated) contains meprobamate, 200 mg.; PATHILON tridihexethyl chloride, 25 mg.

Administration and Dosage: **PATHIBAMATE-400**—1 tablet three times a day at mealtime and 2 tablets at bedtime.

PATHIBAMATE-200—1 or 2 tablets three times a day at mealtime and 2 tablets at bedtime.

Adjust dosage to patient response.

Contraindications: glaucoma; pyloric obstruction, and obstruction of the urinary bladder neck.



LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

HOW TO RETIRE ON (NOT IN) A NURSING HOME

charged. Comments Dr. Fahrney: "The board would like us to charge \$5 a day for added nursing care, but we think that might be too high. We start charging for extra care when a patient needs a great deal of attention. For instance, if there's bed-wetting two or three times a day, we make no charge; but if it's twenty-five times a day, we'll charge \$3."

Patients are also billed extra for all drugs, laboratory work, and X-rays. The home's markup of 40 per cent on drugs, and about 100 per cent on lab tests

follows hospital patterns of charging.

According to Dr. Fahrney, it costs the home about \$6 to provide a day of patient-care. (Of this amount, only 80 cents goes for food.) If everybody paid full rates, Vindobona's profit would be considerable. But some patients are on public assistance when they come in. And the state pays only \$3.75 a day for their care.

Others run out of money while they're at Vindobona. But such persons are never compelled to leave. "Naturally,"



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for allergic patients who must
remain active and alert

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NURSING HOME

says Dr. Fahrney, "we wouldn't kick anyone out for nonpayment. And we make no credit investigation of the patients doctors refer to us. If a patient who has been here a while runs out of money, we just put him on state care."

Relations With Doctors

At first, Dr. Fahrney concedes, other physicians were "very skeptical and aloof." The home had been open four months before the first outside doctor sent in a patient. It's a different story now. Of about

Amusing ...

Amazing ...

Embarrassing ...

No doubt one of these adjectives describes some incident that has occurred in the course of your training.

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If it's accepted for publication, you'll receive \$25-\$40 for it.

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in
respiratory
infections

the new alternative



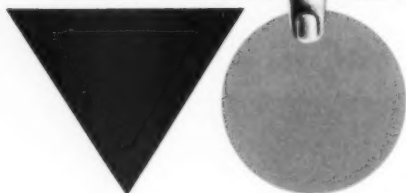
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"...its simplicity of administration, safety, clinical response and reasonable cost make... [Madribon] a desirable drug in instances where it is equally effective [as the antibiotics], and a choice drug in many antibiotic-resistant cases."

M. J. Mosely, Jr., *J. Nat. M. A.*, 51:258, July 1959.

in
respiratory
infections

the new alternative



In 25 years, the antibacterials have progressed from the status of heroic therapy to "universal" medication. This has brought into focus certain unexpected problems relating both to bacterial and to host response.

Shifts in bacterial flora—particularly of the gastrointestinal, as well as the respiratory and urinary tracts—pose entirely new therapeutic problems. The emergence of resistant strains of bacteria creates still another hazard. In addition, anaphylactic reactions often hamper critically needed therapy.

While the question of bacterial mutations and patient sensitivity is undergoing continual intensive study, the immediate clinical need is for a new anti-infective alternative.

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NEW MADRIBON PEDIATRIC DROPS

(12.5 mg / drop)

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the safer, one-dose-a-day sulfonamide

- wide-spectrum activity
- high rate of clinical effectiveness—up to 90 per cent
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- minimal risk of hazardous superinfections
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- reserves antibiotic effectiveness for fulminating, life-threatening infections

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125-mg capsule form of Madribon

in respiratory infections

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dosage:

for severe infections

MADRIBON TABLETS	0.5 Gm	MADRIBON PEDIATRIC DROPS		
MADRIBON SUSPENSION	0.25 Gm/teasp. (5 cc)	12.5 mg/drop		
MADRIQID CAPSULES	125 mg			
	first day	q. 24 hrs.	first day	q. 24 hrs.
Adults	2 Gm	1 Gm		
Children: 20 lbs	0.5 Gm	0.25 Gm	25 mg (2	12.5 mg (1 drop)
40 lbs	1 Gm	0.5 Gm	drops) per lb	per lb body
80 lbs	2 Gm	1 Gm	body weight.	weight.

Continue therapy for 5 to 7 days or until patient is asymptomatic for at least 48 hours.

for milder infections

Less severe infections will usually respond to one-half the above dosage.

Caution: The usual precautions in sulfonamide therapy should be observed, including maintenance of adequate fluid intake. If toxic reactions or blood dyscrasias occur, use of the drug should be discontinued. Madribon, like most sulfonamides and certain other drugs, is probably contraindicated in premature infants and newborns for the first week of life due to underdeveloped enzyme systems and liver and renal functions.

Supplied: MADRIBON TABLETS: 0.5 Gm, double scored, monogrammed, gold colored—bottles of 30, 250 and 1000. MADRIQID CAPSULES: 125 mg, gold colored—bottles of 100 and 1000. MADRIBON SUSPENSION: 0.25 Gm/teasp. (5 cc), custard flavored—bottles of 4 oz and 16 oz. MADRIBON PEDIATRIC DROPS: 10-cc plastic container with special tip for dispensing drop dosage—each cc (20 drops) provides 250 mg Madribon.



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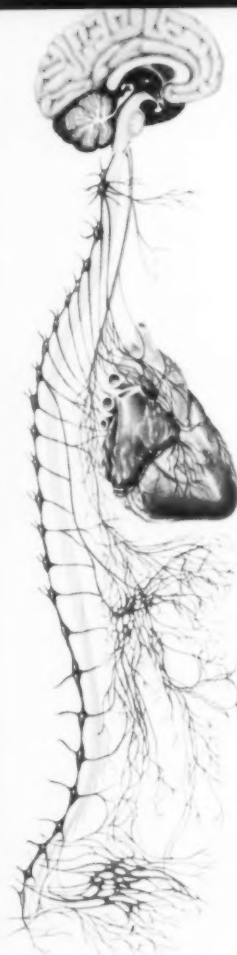
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and the evidence mounts

In two recent studies, involving 179 mixed anxiety and hypertensive patients—Harmonyl produced far less lethargy and listlessness than Reserpine—and yet with comparable potency and effectiveness.

Below, two charts taken from these reports dramatically illustrate the exceptionally low incidence of side reactions with Harmonyl.

RESULTS OF "DOUBLE-BLIND" STUDY OF 99 MIXED ANXIETY AND TENSION PATIENTS*

Side Effects	Tablet A Deserpidine 43 patients	Tablet C Placebo 24 patients	Tablet C Reserpine 27 patients
DIZZINESS	0 (0%)	3 (12%)	4 (15%)
DRYNESS OF MOUTH	3 (7%)	1 (4%)	6 (22%)
BIZARRE DREAMS	0 (0%)	2 (8%)	7 (26%)
LISTLESSNESS	1 (2%)	4 (17%)	9 (33%)
DETACHMENT (Diminished awareness)	0 (0%)	0 (0%)	2 (7%)
ANOREXIA	1 (2%)	3 (12%)	4 (15%)
WEAKNESS, TIREDNESS, NO PEP	0 (0%)	8 (33%)	16 (59%)
DAYTIME SLEEPINESS	1 (2%)	4 (17%)	19 (70%)
HEADACHE	0 (0%)	18 (75%)	4 (15%)
NAUSEA	0 (0%)	2 (8%)	3 (11%)
ABDOMINAL CRAMPS	1 (2%)	4 (17%)	5 (18%)
RASH	0 (0%)	0 (0%)	0 (0%)
NASAL STUFFINESS	1 (2%)	0 (0%)	4 (15%)
LOOSE STOOLS	0 (0%)	1 (4%)	3 (11%)

Percentages supplied by Abbott Laboratories.

Author's Comments: "With deserpidine there was less abrupt hypotensive action on blood pressure than with reserpine, and less fatigue or sleepiness during the day."

COMPARISON OF SIDE EFFECTS IN 80 HYPERTENSIVES TREATED WITH VARIOUS FORMS OF RAUWOLFIA*

Side Effects	Reserpine	Alseroxylon	Deserpidine	Rescinnamine
LETHARGY	11	10	1	1
NASAL OBSTRUCTION	10	8	8	2
DREAMS	8	7	3	1
ACHING	6	7	3	0
DEPRESSION	3	3	0	1
DIARRHEA	2	3	1	0

Author's Comments: "Deserpidine when given in the morning, showed a definitely lower incidence of lethargy, and depression was not encountered in any patient."

1. Frohman, I. P., *Tranquilizers in General Practice and Clinical Evaluation of Deserpidine, an Alkaloid of Rauwolfia, Canescens*, M. Ann. District of Columbia, 27:641, December, 1958.

2. Winsor, T., *Comparative Effects of Various Rauwolfia Alkaloids in Hypertension, Diseases of the Chest*, April, 1959.

Harmonyl®

(Deserpidine, Abbott)

for your next working hypertensive



thirty doctors in the area who have some geriatric patients, roughly half send cases to Vindobona.

The home follows an open-staff policy, so that any doctor can have his patients admitted. Admission is on a first-come, first-served basis. "The fact that I own stock in the corporation gets me no special privileges in this respect," Dr. Fahrney claims.

He feels that physicians gave the home a cool response at first because nursing homes had a generally bad reputation in the area. "The nursing-home concept has undergone a lot of change in the last five years," he points out. "It used to be that anybody's back room could be called a 'nursing home.' The doctors around here had to be convinced that Vindobona was a modern institution, run like a hospital."

He's the Boss

As major stockholder, chief administrator, and medical director of Vindobona, Dr. Fahrney is virtually free to run the home as he sees fit. But this doesn't stop the board members from battling to keep costs down.

The doctor takes a long-range view of things: "We want to do the best for the home and the patients." And some of the board members evidently feel that his attitude isn't sufficiently businesslike. "We keep spending more money than they think we should, and they raise hell," he says. "Like the time Mrs. Snyder spent \$400 for linens. We weren't suppose to spend over \$100 without getting the board's O.K. Well, those linens were on sale cheap, and we needed them. So we went ahead and bought them."

For the most part, though, relations between the professional staff and the board's business-



HOW TO RETIRE ON (NOT IN) A NURSING HOME

men are good. One reason: Everybody apparently knows that Dr. Fahrney usually gets his amiable way in the long run.

"I just sit by and let them yell," he says. "But when I want something done, I tell them I want it. And I get it. After all, I'm closest to the situation and know more about what's going on than anybody else on the board."

Nobody would dare dispute those words. Nor would anyone deny that Vindobona is Dr. Fahrney's brain child, and that the work he has put into building

up the home has been done without pay.

"I'll vote myself a salary pretty soon," he says now. "I'm entitled to it." But he isn't really concerned about adding to his current income. What he mainly wants is to keep Vindobona in apple-pie order for the years to come.

In a few years, he expects Vindobona to keep *him*. He's one doctor who doesn't dread retirement. "I'll have no money worries," he explains. "And I'll have a useful project to occupy my mind." END

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Effective alone in mild to
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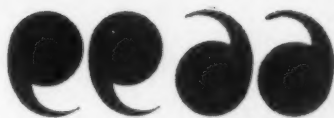
DOSAGE: Up to 0.5 mg. daily for
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 (yellow) and 0.5 mg. (salmon).

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MODERIL—a purified alkaloid of Rauwolfia—lessens the frequency and severity of reserpine side effects,¹⁻¹⁰ such as:

• sedation • bradycardia •
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• fatigue • lassitude •
• sleepiness • nightmares
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"as effective an hypotensive agent as reserpine... producing less side effects"¹

"a safe, easily tolerated agent for chronic drug administration..."²

"produces less sedation and less bradycardia in proportion to its hypotensive dose than does reserpine."³

"Reserpine produces more weakness, fatigue, and sedation... In this series reserpine produced mental depression in a number of cases, and this was not observed with rescinnamine [MODERIL]..."⁴

"Sedation and bradycardia, in particular, appear to occur less frequently and in mild form with rescinnamine."⁵

"mild depressions, nightmares or excessive drowsiness have been relieved on transfer to equally hypotensive doses of... rescinnamine. The increase of appetite that often follows the administration of reserpine has been lacking and even replaced by decrease of appetite on transfer to rescinnamine."⁶

"rescinnamine has less slowing effect on the heart than does reserpine and apparently has less gastrointestinal effect."⁷

"the addition of rescinnamine reduced the need for high doses of ganglion-blocking agents."⁸

MODERIL BIBLIOGRAPHY 1. Winton, S. S.: *Internat. Rec. Med.* 170:665, 1957. 2. Marshberger, R. L.; Dennis, E. W., and Moyer, J. H.: *Am. J. M. Sc.* 231:542, 1956. 3. Moyer, J. H.: *A. M. A. Arch. Int. Med.* 96:518, 1955. 4. Moyer, J. H.; Dennis, E., and Ford, R.: *Ibid.* p. 530. 5. Council on Drugs, A. M. A.: *New and Nonofficial Drugs* 1959, Philadelphia, Lippincott, 1959, p. 374. 6. Smirk, F. H.: *Postgrad. Med.* 25:11, 1959. 7. Moyer, J. H., et al.: *South. M. J.* 50:499, 1957. 8. Malamud, W., et al.: *Am. J. Psychiat.* 114:193, 1957. 9. Smirk, F. H., and McQueen, E. G.: *Lancet* 2:115, 1955. 10. Malitz, S.: *J. Chron. Dis.* 9:276, 1959.



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Investment Counselors: Prices, Pros, Cons

Continued from 109

finding a good fund that roughly matches your own investment objectives.

But a drawback the funds may have for you is that they can't give you the personal attention a counselor can. Nor can they change your holdings to meet your changing needs. And here's

something that may surprise you: If you have a large amount of money to invest, a mutual fund may be more expensive—not less—than a personal investment counselor.

How much does a personal investment counselor charge?

His fee nearly always depends on the amount of money you have to invest. Rates vary, of course, but the most common figure is one-half of 1 per cent per year of the market value of your holdings. On that basis, the fee for handling a \$100,000 portfolio would be \$500 a year—

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A striking development in psychopharmacology now permits a more direct approach to the treatment of cardiophobias and gastrointestinal neuroses. Sycotrol is designated "as an 'antiphobic' compound, as distinguished from...tranquilizing substances"¹ because "It tends to abolish fears and resulting neurotic responses engendered by anxiety and stress"² without depressing or sedating the patient. The patient is diverted from the target organ, not dissociated from the need to overcome his problems.

DOSAGE: one 3 mg. tablet three or four times daily.

SUPPLIED: Bottles of 100.

REFERENCES: 1. Rosenblum, L.A.; Clin. Med. 6:73, 1959.
2. Rosenblum, L.A.; Antibiot. Med. & Clin. Ther. June, 1959.

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deductible from your income tax, of course.

That rate is about the same as the annual management fee charged by most mutual funds. And when you buy shares in a mutual fund, you usually also have to pay an initial 8 per cent loading charge. That's why a mutual may turn out to be more expensive for large investors than a personal counselor.

But for small investors, a counselor may be much more expensive. That's because, in addition to the flat percentage fee, most counselors set an annual

minimum charge. Usually it's between \$250 and \$500, but sometimes it's more. It's because of this minimum that the less you have to invest, the relatively more expensive it becomes to retain a personal counselor.

Since counseling firms charge a percentage of the value of your portfolio, do they place a minimum on the size portfolio they'll accept?

Not necessarily. While most of their clients have upwards of \$50,000 to invest, many top companies will work with people who have only \$20,000 or

WHEN THE TARGET ORGAN IS THE G. I. TRACT ...AND **PEPTIC ULCER** RESULTS



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Chemotherapy directed specifically against the fear-anxiety component of peptic ulcer is now possible with the anti-phobic Sycotrol. For this reason it is the keystone of the Modutrol approach to total therapy. Modutrol—a combination of Sycotrol with preferred antacids and an effective, well-tolerated anticholinergic—has proven highly successful as sole therapy for peptic ulcer; dietary restrictions have been shown to be unnecessary!

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SUPPLIED: Bottles of 50 tablets.

DOSAGE: 1 tablet q.i.d. or as indicated.

1. Rosenblum, L.A.: Clin Med. 6:73, 1959.

*Contains the antiphobic SYCOTROL for the fear anxiety component.

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MEDICAL ECONOMICS • SEPTEMBER 28, 1959 225

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with low back pain
to return to
normal activity
when you prescribe
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case profile no. 2758

A middle-aged man had intermittent low back pain that he attributed to injuries received in an automobile accident three years previously. The pain radiated down both legs, making the patient walk bent over. He also had difficulty getting out of bed and had to pull his knees up and roll out. Heavy lifting precipitated a new attack; and he tired easily.

Findings on x-ray of the thoracic and lumbar spine gave negative results. Findings from all other laboratory studies were within normal limits. A herniated disc, although still a possibility, was temporarily ruled out by the neurologic examination. Previous treatment consisted of analgesics and steroids (without success), and narcotics were given during severe attacks.

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*Clinical Report on file at the Department of
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Indications - Musculoskeletal: Low back pain (lumbago, sacroiliac pain, etc.); neck pain (torticollis, etc.); bursitis; rheumatoid arthritis; osteoarthritis; disc syndrome; fibrositis; ankle sprain, tennis elbow; myositis; postoperative muscle spasm. **Psychogenic:** Anxiety and tension states; dysmenorrhea; premenstrual tension; asthma; angina pectoris; alcoholism.

Dosage: 100 to 200 mg. orally three or four times daily. Relief of symptoms occurs in fifteen to thirty minutes and lasts from four to six hours.

Supplied: Trancopal Caplets® 100 mg. (peach colored, scored), bottles of 100.

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Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U.S. Pat. Off. 1394M

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Laboratories



ANNIVERSARY

1949

1959



WANT TO REACH RESIDENTS AND INTERNES?

If you're looking for a new associate, selling a practice, or announcing something of special interest to young physicians, tell them about it in the RISS Edition of MEDICAL ECONOMICS. Each month it's read by 25,000 residents, 10,000 internes, and many senior students. An announcement in the new classified advertising section of RISS costs only \$5 for the first three lines (about 20 words), \$1.50 for each additional line (about 6-7 words). Write RISS, Incorporated, Oradell, N.J.

INVESTMENT COUNSELORS

\$30,000 accounts. Some will handle even smaller accounts.

"We're much more interested in how fast a doctor's account is growing than in its initial size," says David L. Babson, head of the Boston counseling firm that bears his name. "After all, every big fund was once a little fund."

From your point of view, does it make much sense to spend several hundred dollars a year to have an investment counselor manage, say, \$20,000 worth of securities for you?

Only you can come up with the final answer. But here are two tests to guide your thinking:

¶ Are dividends your major interest? Then a counselor's fee would loom large indeed. Blue-chip stocks are now paying only 2 to 4 per cent. The cost of managing a small account would eat up between one-quarter and one-half of that return.

¶ Are you investing for capital gains? If so, the value of good advice can far outweigh its cost to you.

Ten year ago, for example, an Eastern M.D. turned his modest portfolio over to a New York City counselor. Over the years, he has paid the counselor almost \$5,000 in fees. But just one decision made by the counselor when he took over the account—

To know how to grow
old is the master-
work of wisdom..."

AMIEL



for your "over forty" patients prescribe

ELDEC® KAPSEALS®

min-mineral-hormone supplement

help fill their later years with vigor and vitality

each KAPSEAL contains:

vitamins

Vitamin A	1,667 Units (0.5 mg.)
Vitamin B ₁ mononitrate	0.67 mg.
Ascorbic acid	33.3 mg.
Nicotinamide	16.7 mg.
Vitamin B ₆	0.67 mg.
Vitamin B ₁₂	0.5 mg.
Vitamin B ₁₂ with intrinsic factor concentrate	0.033 USP Unit (oral)
Folic Acid	0.1 mg.
Choline bitartrate	6.67 mg.
Pantothenic acid (as the sodium salt)	5 mg.

minerals

Ferrous sulfate (exsiccated)	16.7 mg.
Iodine (as potassium iodide)	0.05 mg.
Calcium carbonate	66.7 mg.

digestive enzymes

Taka-Diastase (Aspergillus Oryzae Enzymes)	20 mg.
Pancreatin	133.3 mg.

protein improvement factors

L-Lysine monohydrochloride	66.7 mg.
dl-Methionine	16.7 mg.

gonadal hormones

Methyl testosterone	1.67 mg.
Theelin	0.167 mg.

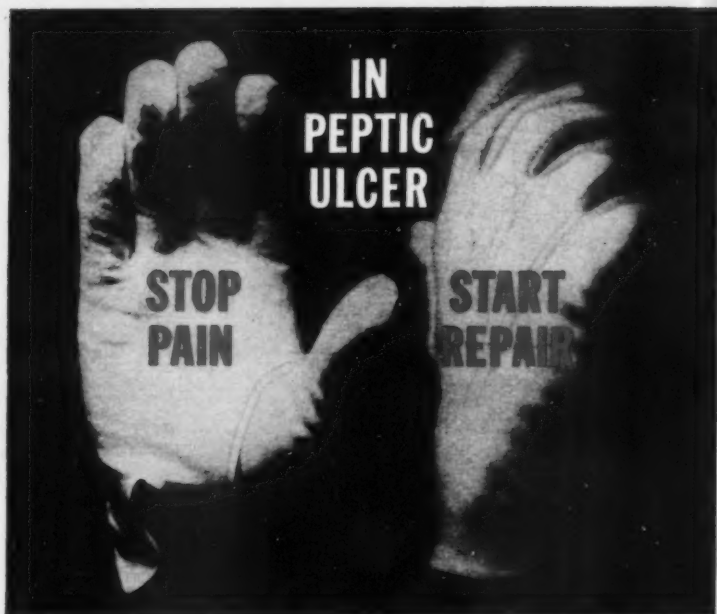
dosage: One Kapsel three times daily before
meals. Female patients should follow each
21-day course with a 7-day rest interval.

packaging: ELDEC Kapsels are available in
bottles of 100.



PARKE, DAVIS & COMPANY, Detroit 32, Michigan

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Provides 4 necessary healing actions in one medication¹...1. stops spasm — relieves pain; 2. neutralizes acid — with prompt-acting, long-lasting ant-acid combination free of constipation or laxation; 3. halts erosion — curbs necrotic effects of pepsin and lysozyme; 4. promotes healing — with soothing, protective coating on ulcerated area.

Dosage: 1 tablespoonful gel, or 2 tablets, every three hours as needed.

1. Hufford, A. R.: Rev. of Gastroenterology 18:588.

Formula: each tablet or 10 cc. gel contains —
 Bentyt (dicyclomine) hydrochloride . . . 5 mg.
 Aluminum hydroxide gel 400 mg.
 Magnesium oxide 200 mg.
 Methylcellulose 100 mg.
 Sodium lauryl sulfate 25 mg.

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TRADEMARK: KOLANTYL®

pleasant-
tasting,
mint-
flavored

KOLANTYL GEL



INVESTMENT COUNSELORS: PRICES, PROS, CONS

switching from \$5,000 in Curtis Publishing stock to \$5,000 in McGraw-Hill—has made a \$33,500 net profit for the doctor.

Of course, reputable counselors won't claim they can help you that much. But they do claim to achieve better results than the average investor could by himself. Says A. Vere Shaw, head of the New York firm of that name:

"Unless a counselor turns in a better performance than you could yourself, good enough to more than pay for his fee, there's no reason to engage him."

How to Pick Them

If you're interested in taking on an investment counselor, how can you locate a good one?

First, speak to your friends and colleagues and see if they've had any experience with investment counselors. Ask your banker and your stockbroker too.

Once you've got some nominations, get in touch with the men nominated. Ask them directly what their qualifications are. Ask to see samples of the portfolios they've managed.

Ask especially if they're registered with the Securities and Exchange Commission. Except

for banks, all investment advisers with more than fifteen clients are required to register and to supply information about their education, business experience, etc. The S.E.C. can't deny registration to anyone because of lack of training or experience, but it has persuaded a number of unqualified applicants to withdraw their applications.

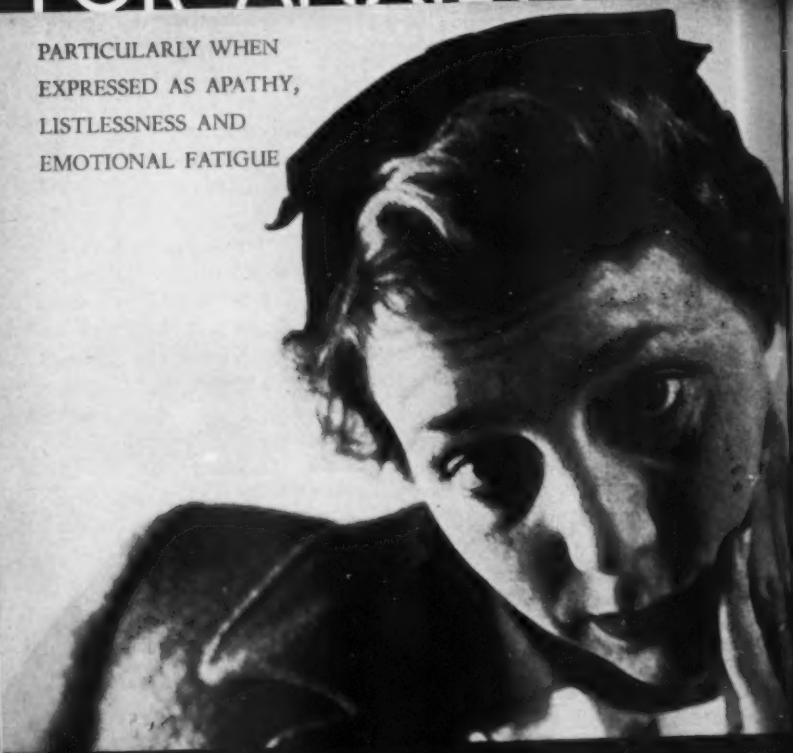
Don't overlook the investment advisory publications that also offer individual counseling services. If you've had good experience with such a publication, you might want to consider using its counseling service. And many banks also offer individual investment counseling help, as well as custody service for securities.

A few investment counseling



FOR ANXIETY-

PARTICULARLY WHEN
EXPRESSED AS APATHY,
LISTLESSNESS AND
EMOTIONAL FATIGUE



STELAZINE®

brand of trifluoperazine

OFFERS 5 SIGNIFICANT ADVANTAGES

1. Often effective where other agents fail

Clinical experience in over 12,000 patients has shown that many patients who had failed to respond or responded poorly to meprobamate, prochlorperazine, phenobarbital, mepazine, chlorpromazine, or promazine were promptly relieved by 'Stelazine'.

2. Enthusiastic patient acceptance

Clinicians note that 'Stelazine' therapy is unusually well accepted by patients. Subjective relief is frequently superior to that experienced with other therapies and in many patients normal mental acuity and alertness are restored. Annoying side effects, such as drowsiness, are rarely encountered in recommended doses.

3. Fast therapeutic response with very low oral doses

Most patients on 'Stelazine' enjoy good to excellent relief of anxiety symptoms within a short time—often within 24 to 48 hours—on daily doses of one 1 mg. tablet b.i.d.

4. Convenient b.i.d. administration, due to inherent long action

Laboratory tests and extensive clinical investigations have demonstrated that 'Stelazine' exerts a significant therapeutic effect for 12 hours or more. Thus, you can control symptoms with b.i.d. dosage and with convenient morning and evening doses your patients need not interrupt their daily routines for midday medication.

5. Side effects slight and transitory; rarely interfere with therapy

In the recommended dosage range of 2 mg. to 4 mg. daily, side effects with 'Stelazine' are infrequent, usually slight and transitory, and rarely affect the course of therapy. Occasional instances of drowsiness, dizziness, or stimulation may be observed; rarely, symptoms of an extrapyramidal nature may occur.

AVAILABLE: 1 mg. tablets in bottles of 50 and 500. USUAL ADULT DOSAGE: One 1 mg. tablet b.i.d. ADDITIONAL INFORMATION on dosage, cautions and contraindications available on request. Smith Kline & French Laboratories, leaders in psychopharmaceutical research

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Cramps, Burn-
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Prescribe Dr. Scholl's Arch Supports in cases requiring mechanical relief from Foot Arch trouble of any kind. The patient will be properly fitted and the Supports adjusted as the condition of the foot warrants, at no extra cost. This nation-wide service is available at many leading Shoe and Department Stores and at Dr. Scholl's Foot Comfort® Shops in principal cities throughout the world.

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INVESTMENT COUNSELORS

firms sponsor mutual funds—for example, Eaton & Howard; Loomis, Sayles; Scudder, Stevens & Clark. If a counselor sponsors a fund, the record of that fund should give you some indication of how well he could do for you.

Most of the independent counseling firms belong to the Investment Counsel Association of America. You can get a list of the members and their branch offices by writing to the association at 100 Park Avenue, New York 17, N.Y.

Even the best-qualified investment counselors may make mistakes with your money. "Counselors don't claim to be infallible or omniscient," says the association. "Any doctor could collect the same facts.

"But compiling, interpreting, and applying those facts takes time, training, and experience. Investment counselors are specialists in that work. They live by their investing skill."

Should you hire the skill of such a man? It depends on how he fits into your investment picture. For you, his fee might be a needless expense. Or it could be the best investment you've ever made. Now that you've read this article, you're probably better able to decide.

END

PROZINE offers effective aid in the treatment of many organic symptoms arising from moderate to severe emotional disturbance. For example, PROZINE produced improvement in 62 of 74 patients¹ with anxiety neuroses accompanied by nausea, vomiting, tremor, palpitations, or fear. In another 57 patients² suffering from nausea and vomiting, PROZINE benefited over 90 per cent.

Designed for everyday practice, PROZINE controls motor excitability as well as anxiety and tension by acting on both the hypothalamic and thalamic areas of the brain. Because of this dual action, dosage requirements are low, side-effects minimal.

1. Case reports on file, Wyeth Laboratories. 2. Parks, R.V., and Moessner, G.F.: Dual Approach to Patient Care, Scientific Exhibit, A.A.G.P., April, 1959.

"Nausea and vomiting? Not any more!"



Affects the thalamic and hypothalamic areas of the brain

PROZINE *

meprobamate and promazine hydrochloride, Wyeth

SPECIFIC CONTROL THROUGH DUAL ACTION



*Trademark

Pharmacia Inc. Pa.

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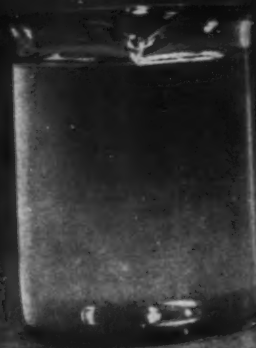
...avoiding the risk of insoluble, irritating aspirin particles. The reason is simple: Aspirin is a weak acid. When it comes in contact with water, it breaks down into salicylic acid and acetic acid. Salicylic acid is a weak acid, and acetic acid is a strong acid. Both of these acids are irritating to the stomach lining. Aspirin particles that do not dissolve in water can irritate the stomach lining and cause ulcers. This is why it is important to avoid insoluble aspirin particles.

...insoluble, irritating aspirin particles. The reason is simple: Aspirin is a weak acid. When it comes in contact with water, it breaks down into salicylic acid and acetic acid. Salicylic acid is a weak acid, and acetic acid is a strong acid. Both of these acids are irritating to the stomach lining. Aspirin particles that do not dissolve in water can irritate the stomach lining and cause ulcers. This is why it is important to avoid insoluble aspirin particles.

CALUMIN is the truly soluble, stable form of aspirin particles. It has no risk of insoluble aspirin particles or damage.



Insoluble aspirin crystal at bottom of glass, being added to water.



Calumin crystals in solution one minute after being mixed into water.

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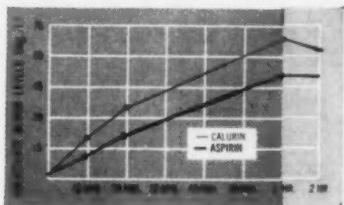
XUM

CALURIN*

STABLE SOLUBLE CALCIUM-ACETYSALICYLATE-CARBAMIDE



Aspirin-induced ulceration — section through specimen found in gastrectomy specimen. An aspirin ulcer was found firmly imbedded in this underlined erosion. Such lesions may be associated with the relative insolubility of aspirin, which remains in particulate form after dispersion in gastric contents.



Calurin, being freely soluble, is promptly available for absorption into the systemic circulation. Salicylate blood levels in 12 subjects receiving both Calurin and plain aspirin were found to rise more than twice as high within ten minutes following Calurin. Also, these levels persisted higher for at least two hours.¹¹

CALURIN is the aspirin of choice, especially when high-dosage, long-term therapy is indicated:

- 1 High solubility forestalls gastric irritation or damage. This advantage is of special importance in arthritis and other conditions requiring high-dosage, long-term therapy.
- 2 Produces high salicylate blood levels rapidly for prompt analgesic, anti-pyretic, anti-arthritis effect.
- 3 Sodium-free — for safer long-term therapy.
- 4 Flavored: can be chewed or dissolved in the mouth without water if desired — an advantage for patients requiring aspirin administration during the night and for pediatric patients.

Each tablet of Calurin is equivalent to 300 (5 gr.) of acetylsalicylic acid. For relief of pain fever in adult patients, the usual dose of Calurin is 2 tablets every 4 hours, as needed; in arthritic patients, 2 or 3 tablets 3 or 4 times daily; in rheumatic

fever, 3 to 5 tablets 4 or 5 times daily. For children over 6 years, the usual dose is 1 tablet every 4 hours; for children 3 to 6 years, ½ tablet every 4 hours, as required. Not recommended for children under 3.

REFERENCES: 1. Waterson, A. P.: Aspirin and gastric haemorrhage, *Brit. M. J.* 2:1531, 1955. 2. Douthwaite, A. H., and Lintoff, M.: Gastroscopic observation of the effect of aspirin and certain other substances on the stomach, *Lancet* 2:1222, 1938. 3. Editorial Comments: The effect of acetylsalicylic acid (aspirin) on the gastric mucosa, *Canad. M. A. J.* 80:47, 1959. 4. Muir, I. A.: Aspirin and ulcer, *Brit. M. J.* 2:7, 1955. 5. Muir, A., and Cossar, I. A.: Aspirin and gastric haemorrhage, *Lancet* 1:1959. 6. Schneider, E. M.: Aspirin as a gastric irritant, *Gastroenterology* 33:616, 1957. 7. Bayles, T. B., and Tenckhoff, H.: Salicylate therapy in rheumatic diseases, Scientific Exhibit, Ann. Mtg. A. M. A., San Francisco, Calif., June, 1958. 8. Batterman, R. C.: Comparison of buffered and unbuffered acetylsalicylic acid, *New Eng. J. M.* 258:213, 1958. 9. Cronk, G. A.: Laboratory clinical studies with buffered and nonbuffered acetylsalicylic acid, *New Eng. J. M.* 258:219, 1958. 10. Editorial: Aspirin buffered, *Brit. M. J.* 1:349, 1959. 11. Smith, P. K.: Plasma concentration of salicylate after the administration of salicylic acid or calcium acetylsalicylate to human subjects. Report submitted to Smith-Dorsey from Dept. of Pharmacology, Washington Univ. School of Medicine, Washington, D. C., Sept. 5, 1958.

PHARMACEUTICAL

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

How I Dictate While Driving

Continued from 110

any of the others. So for \$23 I had the necessary hook-up cords made.

5. **ELECTRIC CONVERTER.** To go easier on my model's mercury battery, I had an AC-DC converter installed in my car. This allows me to operate the recorder off the auto battery. It's well worth the \$40 it cost me. (A new recorder on the market has a battery that can be recharged from a wall socket. Using it, you can run the recorder in your car, then charge up the battery when you get back to your office.)

Just Like on TV

6. **OVERHEAD MICROPHONE.** I didn't want to be enmeshed in a microphone cord while I drove. Nor did I want my vision obstructed. So I had an overhead mike mounted on the ceiling of the car. Cost (with installation): \$35.

7. **FOOT PEDAL.** I also wanted both hands free while I drove. A \$15 foot switch provides the perfect answer. Since my tran-

sistorized recorder needs no warming up, I can start dictating the instant I step on the switch.

In all, I've invested about \$500 in my equipment. A lot of money? Not as I see it. Look at all the benefits I get:

More Leisure Time Now

First is the obvious saving in time. By dictating during the time I used to waste while driving, I now have more free hours with my family. And I'm no longer hurried with my patients, friends, and colleagues.

There are other advantages too. Once I've dictated a given patient's record, I can forget about it until I see that patient again. And since I dictate free information as well, I no longer have to take an account book with me while I'm making house calls.

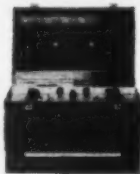
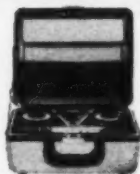
Records Are Complete

What's more, I find I'm now keeping better records. First, because I dictate them while the details are fresh in my mind. And, second, because all the records—both the hospitals' and my own—are kept right up to date. That could make a vital difference in an emergency. END

accent on versatility

accent on portability

one
plus
one
equals
two



AN ELECTROCARDIOGRAPH for maximum usefulness in your office examining room . . . and an electrocardiograph that you can easily *take with you* on any call — are the reasons Sanborn Company developed the 100 Viso and 300 Visette ECG's.

Both produce permanent, easily interpreted, diagnostically accurate electrocardiograms. Both are simple to operate . . . and both will give stable, trouble-free operation year after year. But there are also these important differences: in the 18-pound Visette, every practical means is used to achieve the combination of extremely light weight, brief case size and "traveling" ruggedness. In the new 100 Viso for office use, where instrument portability is not a prime requirement, the design includes such additional features as *two* recording speeds, *three* recording sensitivities, provision for recording *other* waveforms, and *visual* monitoring by an external oscilloscope.

Each of these companion cardiographs has individual emphasis in terms of *portability* and *versatility*. But both equally reflect the best principles of modern diagnostic instrument design.

SANBORN COMPANY
MEDICAL DIVISION
573 WYMAN ST., WALTHAM 54, MASS.

Model 300 Visette, 625 dollars.
Model 100 Viso, 850 dollars.
Delivered prices, continental U. S. A.

NOW

*...a new way
to relieve pain
and stiffness
in muscles
and joints*

INDICATED IN:

MUSCLE STIFFNESS

LUMBOSACRAL STRAIN

SACROILIAC STRAIN

WHIPLASH INJURY

BURSITIS

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"TIGHT NECK"

TRAUMATIC STRAINS
AND BRUISES

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MYALGIA



- Exhibits unusual analgesic properties, different from those of any other drug
- Specific and superior in relief of SOMATIC pain
- Modifies central perception of pain without abolishing natural defense reflexes
- Relaxes abnormal tension of skeletal muscle

SOMA

N-isopropyl-2-methyl-2-propyl-1, 3-propanediol dicarbamate

- more specific than salicylates
- less drastic than steroids
- more effective than muscle relaxants

SOMA has an unique analgesic action. It apparently modifies central pain perception without abolishing peripheral pain reflexes. **SOMA** is particularly effective in relieving joint pain. Patients say that they feel better and sleep better with **SOMA** than with any previously used analgesic, sedative or relaxant drug.

SOMA also relaxes muscle hypertonia, with its stresses on related joints, ligaments and skeletal structures.

ACTS FAST. Pain-relieving and relaxant effects start in 30 minutes and last 6 hours.

NOTABLY SAFE. Toxicity of **SOMA** is extremely low. No effects on liver, endocrine system, blood pressure, blood picture or urine have been reported. Some patients may become sleepy on high dosage.

EASY TO USE. Usual adult dose is one 350 mg. tablet 3 times daily and at bedtime.

SUPPLIED: Bottles of 50 white sugar-coated 350 mg. tablets.

Literature and samples on request.



WALLACE LABORATORIES, NEW BRUNSWICK, N. J.

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THE CORNERSTONE OF
ANTIHYPERTENSIVE THERAPY

HELPS RELIEVE
THE PRESSURES
IN YOUR PATIENTS

HELPS RELIEVE
THE PRESSURES
ON YOUR PATIENTS

SUPPLY: 50 AND 100 MG. TABLETS, BOTTLES OF 100, 1000 AND 5000

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when her periods stop
(but symptoms continue)



...start TACE

(chlorotrianisene)



Symptom-free adjustment to the postmenopausal state

New estrogen approach to the postmenopause

Menopausal distress rarely ends with cessation of menses. Indeed, symptoms are often intensified following the sharp drop in available endogenous estrogen during the early postmenopause.

At that time — when periods stop but symptoms continue — TACE is most valuable.

Note this essential difference between TACE and other estrogens: TACE stores in body fat, releases slowly, evenly, in the same manner as a natural hormonal secretion. A normal course of TACE therapy is 30 or 60 days. But even after the therapy, estrogenic activity continues, gradually tapers off, finally is exhausted in about 2 months.

This unique "self-regulating" property results in several advantages. Since sudden endometrial change doesn't occur, withdrawal bleeding rarely occurs. Complicated dosage adjustment is unnecessary. Finally, there are no "peak-and-valley" estrogenic effects. The result is a smooth, symptom-free adjustment to the postmenopausal state.

You can observe this unique effect in your patients. Simply prescribe two TACE 12 mg. capsules daily for 30 days. A severe case may require an additional 30-day course.



THE WM. S. MERRELL COMPANY
New York • Cincinnati • St. Thomas, Ontario

TRADEMARK: TACE

Question: Why do so many physicians prefer Cafergot and Cafergot P-B for migraine and other recurrent throbbing headaches?

Answers: By leading clinicians, quoted from their published investigations.



"The highest percentage (83%) of patients with symptomatic relief is obtained by early and adequate administration of ergotamine and caffeine (Cafergot), alone or combined with antispasmodics

and/or sedatives (Cafergot P-B)." (Friedman, A. P.: J.A.M.A. 163:1111, March 30, 1957.)

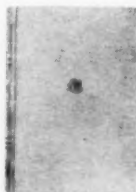
"For those patients in whom nausea and vomiting occur so early in the attack that oral medication cannot be used, rectal administration is sometimes a simple and effective solution. Cafergot suppositories...and Cafergot P-B suppositories...are useful additions to the armamentarium."

(MacNeal, P. S., et al.: Management of the Patient with Headache, 1957.)



"The tablets [Cafergot P-B] were especially useful when the headaches were accompanied by nervous tension and gastrointestinal upset.... Cafergot P-B Tablets constitute an important addition to the treatment of vascular headache."

(Blumenthal, L. S., and Fuchs, M.: Med. Annals District of Columbia 26:175, April 1957.)



"The tablets [Cafergot P-B] were especially useful when the headaches were accompanied by nervous tension and gastro-intestinal upset.... Cafergot P-B Tablets constitute an important addition to the



*first choice
for migraine
and other recurrent,
throbbing headaches*

CAFERGOT®

CAFERGOT TABLETS

ergotamine tartrate 1 mg., caffeine 100 mg.
Dosage: 2 at first signs of attack; if needed, 1 additional tab. every ½ hour until relieved (max. 6 per attack).

CAFERGOT SUPPOSITORIES

ergotamine tartrate 2 mg., caffeine 100 mg.
Dosage: 1 as early as possible in attack; second in one hour, if needed (max. 2 per attack).

When the headache is associated with nervous tension and G.I. disturbance

CAFERGOT P-B TABLETS

ergotamine tartrate 1 mg., caffeine 10 mg., Bellafoline 0.125 mg., pentobarbital sodium 30 mg.
Dosage: same as Cafergot Tablets.

CAFERGOT P-B SUPPOSITORIES

ergotamine tartrate 2 mg., caffeine 10 mg., Bellafoline 0.25 mg., pentobarbital sodium 60 mg.
Dosage: same as Cafergot Suppositories.



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Memo

From the Editors

Hit Between the Eyes

"Your cover stories nearly always hit me between the eyes," an Ohio doctor said to us not long ago. "How do you do it? How do you decide which article to feature on the cover?"

"We almost don't have to decide," he was told. "You and your colleagues do the deciding."

Here's what we mean:

Our incoming mail brings us thousands of practice-connected queries a year. When the same questions keep bobbing up, we know it's time to answer them in print. When the same questions are asked by dozens of different doctors, we know the answers may be worth a cover story.

That's how the cover story in this issue came to be. Doctors started asking us questions about nursing-home ownership some years back. By this summer, it had become clear that many older men were seriously interested. Their detailed questions drove us into detailed research, with the results you've now read.

The next two cover stories ahead got their start in much the same way. One shows it in the title: "Questions They're Asking About Group Practice." It's based on the pointed, personal questions that only practicing physicians would ask. For example:

"How can I tell if I'd make a good group member?"... "Would I be likely to earn more money in a group?"... "What fees should a new group charge?"... "What can a group do to reduce resentment from solo men?"

All these questions and more are answered candidly in our Oct. 12 cover story. If it interests you, thank the solo physicians who started it with their queries.

The greatest number of queries coming in right now concerns payment problems with insured patients. You know the type:

¶ The patient's policy pays far less than the fee. How can you collect without a three-way argument?

¶ The patient's policy pays *more* than your fee. Who's entitled to the extra money?

MEDICAL ECONOMICS has culled answers from all over the country. You'll find them in our Oct. 26 cover story.

Got some other problem? Tell us about it. You may help create some future cover story that'll hit you between the eyes.

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